DHMH 17 Rev 1/2001

Registrar

APR 19

2006

			1 - For State Registrar	State of	of Marylar	-	artment of F		d Mental Hy	/giene	006	130	02
r			1. Decedent's Name (First, Middle, I	.ast)					2. Date of D	eath Day	Yeer	3. Time of	Death
	Physici /Medio		James Polites						April	06,	2006	1:38	p^{M}
	Examin		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City, Town, o	r Location of D	eath	4c. C	County of Death		
		Ш	Shady Grove Nur			4	Rockvi		dro la a		ontgome		
	Funeral		5. Social Security Number 6. 205–16–2433	Sex 1⊠M 2□F	7. Age (In yrs.	ast birthday 81 Yrs.	Months Days		Ain. 8. Date of Bi (Month, D 01/19	ay, Year)	Cour	place (State o	
	Director		Usual Residence of Decedent			01			01/19	/ 1923	ren	nsylva:	пта
	yland Nor		10a. State 10b. County		10c. Cit	y, Town or L	ocation				1	0d. Inside Cit	ty Limits
	Mar.	ctor	Maryland Montgo	mery	R	ockvi]	.1e					1 ⊠ Yes	2 🔲 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cour	ntry?	
	death with the Maryland ms 23a or 28a-f ehow Efficial be notified at		770 Azalea Drive				20850				ted Sta		
30	be filed within 72 hours after death with the Marylar ital Hygliene. Id other than "netural; or flams 23a or 28a-f show event, the Medical Examinet must be neithed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Arm ad E	ve Kore	an 13	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? an, Mexican, Pi Specify:	? (Specify Yes or N Jerto Rican, etc.)		4. Race - Americ Black, White, Specify: Cana		
15-0036	2 hou		15. Decedent's	Education	Wal	16a. Dec	edent's Usual Occup	ation		16b. Kind	of Business/In		
2 2 2	nin 7	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College ((Giv life.	e kind of work done of DO NOT use retired	during most of d)	working			,	
7	e filed within al Hygiene. other then 'vent, the Me	ĕ	8		1-401 3+)	Co	al Miner			Co	a1		
2	al Hy sother	Be (17. Father's Name (First, Middle, La	st)				18. Mother's I	Name (First, Middle	e, Maiden S	'umame)		
yland	2 should be and Mental le marked o raumetic eve	卢	John Polites					Mary	Salis				
Mar	2 short and le m		19a. Informant's Name/Relationship			1	ing Address (Street						
2 0	l and tealth im 27 her to		Juliana Crampt	on / Da		_	zalea Dri osition <i>(Name of</i>	ve; Roc	ckville,				
0	H It of P		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		State	emetery, cre	amatory or other plac	· I			ation - City or To		
saitimore,	rtmen rtant:		* 4 □ Donation 5 □ Other (Spec	•	Ft		oln Crema				ntwood,		and
מ	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any injury or other traumetic ence.		21. Signature of Funeral Service Sic	ensee		S 1	2. Name and Address imple Tri 040 Rockv	bute Fu	ineral an ike: Rock	d Crem ville	mation (, Maryla	Center and 208	352
			23a. Part1. Enter the disease, or co shock, er heart failure. List on	mplications that by one cause on	caused the deat each line.	h. Do not er	nter the mode of dyin	g, such as card	diac or respiratory a	arrest,		Approximate Interval Bety Onset and D	ween
	Physician		Immediate Cause (Final disease or condition	Lung	Cancer							Otiset and L	/eatii
	/Medical Examiner		resulting in death)	_	(or as a conseq	uence of):							
		_	Sequentially list conditions,	b	monia (or as a conseq	uence of):							
	ted nsit	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disuase or hijury	54010	(0. 45 4 50.1504	deribo 017.							
	axecu n and al-tra	Examine	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):					-		
9/60	icate be executed physicien and s the burial-transit	dicall		d.									
200	tificat ig phy as th	ledi		_									
X Q	death certificate be executed e attending physicien and of for use as the burial-transit	ician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		□Ectopic pregnancy	,		23	d. Date of delive	•	
	ed fo	sicia	in the past 12 months? 1 □ Yes 2 □ No		nant at time of d		Other (specify)			4	Month	Day Y	ear ear
л Э	that the de ned by the a detached f	Phys	9 Unknown						00.00				
cords,	w requires that been signed I should be det	þ	Part II. Other significant conditions	contributing to d	leath but not res	uiting in the	underlying cause give	en in Part I.			o contribute to the No 3∰ Prob		
d)	> D 76	ompleted							24a. Was		24b. Were auto	psy findings a	available
	The law cate has page 2:	Con							perfe 1 ☐ Yes	ormed?	death? 1 ☐ Yes		
VITAI	iicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			100-27			Death (Check only	one)			
6	Physicien: this certific ral director,	၉	1 ☐ Yes 2 ☑ No			ER/Outpatie	-	4 ER MUISIN	g Home 5□ Res			()	
	nding Physicien: th.: After this certifics funeral director, is	ertification;	27. Manner of Death 1 ⊠Natural 5 □ Pending		of Injury oth, Day Year)	28b. Time Injury	Worl	yat k? Yes 2 □ No	28d. Describe	how injury	occurred		
DIVISION	deatl deatl ctor: y the	fica	2 Accident investigat 3 Suicide 6 Could not	be Zee Place	of Injury - At he	ome, farm, s	treet, factory, office	103 2 110	28f. Location (Street and	Number or Rura	l Route Numt	ber.
\geq	after after Dire	erti	4 Homicide determine	build	ing, etc. (Specif	y)	reat, factory, office			wn, State)	7,012	, , , , , , , , , , , , , , , , , , , ,	,,,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	edical C	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the	e best of my kno	wledge, dea	th occurred at the tim	ne, date and pla	ace, and due to the	cause(s) at	nd manner as st	ated.	
	the I	Medi	one)	and man	ner stated.		29c. License						
	T vo		29b. Signature and title of certifier	1	V						signed (Month,		
	14+1		20.11		~	70.15	Н005	1280		Apr	il 10,	2006	
			30. Name and address of person wh Anushiravan Dad				.Print) Lcal Cente	r Driv	∍ #2∩1• R	ockwi	11e. MD	20850	
	Sta	te	31. Date filed (Month, Day, Year)					T DITAK	- "2019 K	JURVI.		20000	
	Registr		APR 11	2006	Registrar's Signa	7. 4							

			State AURIKI ILCII Registrar	,	Maryland / Dep per Dr., G855	rillicate of Dea	th	R	eg. No.	O	13003
Di	husisis		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	th Day	Year	3. Time of Death
	hysicia /Medic		Eldred Edward	Prescop					5, 2006		11:19 A ^M
) E:	xamin	er	4a. Facility Name (If not institution,	-	ber)	4b. City, Town, or Locati	on of Death		4c. County	of Death	
			954 Bermuda Lai 5. Social Security Number		. Age (In yrs. last birthday)	Annapolis If Under 1 Year If Uni	der 24 Hrs.	8. Date of Birth	Anne		
	neral ector		553–32–7667	1 M 2 F /.	77 Yrs.	Months Days Hou		(Month, Day	, Year)	Cour	
		t	Usual Residence of Decedent	Α				June 18	1920	Penr	nsylvania
nylan	THOM:	_	10a. State 10b. County		10c. City, Town or Lo					1	Od. fnside City Limits
9 Ma	Ba-r s	8	aryrana	Arundel	Annapo						1 Yes 2 No
tith t	Len	Directo	10e. Street and Number			10f. Zip Code		1	I0g. Citizen of V	Vhat Cour	ntry?
aath v	S 236	rai	954 Bermuda Lai	ne 12. Was Decede	lent Suprim II C 42	21401 Was Decedent of Hispanic	Origina (Con	of Vac at Na	USA	Amari	can Indian,
fter de	Ingri	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Force	es?	If Yes, specify Cuban, Mex	ican, Puerto	Rican, etc.)		k, White,	
21215-0036 ad within 72 hours aff giene.	el, o		3 Widowed 4 □ Divorced	Ifzes, Give Year or Date	es:1950-60	1 ☐ Yes 2 ☐ No Spec	cify:		Specify	Whi	te
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Montal Hougiene.	licel	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usuaf Occupation	nost of worki	na	16b. Kind of Bu		
Z = 5	- WBC	n je	Elementary/Secondary (0-12)	College (1-4	life.	DO NOT use retired)	riost or work.	9			
Yajer N	it, E	8	47 Fabrida blanca (Fina 64) de la	4	Subs	sidy Rate Ana		/F: A () - W	Federa		vernment
and the fi	90 of	Be	17. Father's Name (First, Middle, L.					(First, Middle,	маюеп Битат	Θ)	
Maryland d 2 should be file th and Mental Hy	nark	2	Bartley J. P. 19a. Informant's Name/Relationshi		19h Maili	ng Address (Street and Nu		tkowski	r City or Tour	State 7in	Codel
Ma d 2 s th an	treui		Mark E. Presco			080 Pendragor		Pasader			
Te, N Health	item 27 is marked other then "nature", or items 23s or 23s-1 show other treumstic event, the Medical Evarither is ust be rutified at	ı	20a. Method of Disposition	<u> </u>	20b. Place of Disp	osition (Name of		ate	20c. Location -		
Baltimore	y or e		1 XBurial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Spi		iate	ans Cemetery	4_10-	-06	Crownsv	71116	MD
Baltim permit. Pag Department	Importent: If II any injury or o		21. Signature of Funeral Service Li			2. Name and Address of Fa	acility				
Balt Perrit. Depart	any		> Mulle			2973 Solomons		orge P.			al Home
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cau	used the death. Do not en					iter,	Approximate Interval Between
Pnys	ician		Immediate Cause (Final disease or condition	(Trute	lavel for	lun				Onset and Death
/Me	dical		resulting in death)	Due to (or	r as a consequence of):						0.00
Exan	niner		Sequentially list conditions,	b	ram Negative	Septcemia				2	Day
D.	sit	ine	if any, leading to immediate cause. Enter Underlying	Due to (or	r as a consequance of):						
. Box 68760, death certificate be executed	sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c.	r as a consequence of):					-	
8760, cate be ex	hysician the buria			330 10 (6.	t as a sorisoquerios siy.						
687	≩ <u>\$</u>	dicai		d.						-1	
Box (attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy				23d. Dat	e of defiv	erv
Bath Be	d for u	ciar	in the past 12 months?	4□Pregnar	nt at time of death 5[□Ectopic pregnancy □ Other (s <i>pecify</i>)			Mo		Day Year
O a a	ed by the detached	hys	9 Unknown	9□ Unknow	ν η						
T that	s been signed to	by P	Part II. Other significant condition	ns contributing to dea	ath but not resulting in the u	underlying cause given in P	art I.	23e. Did to	bacco use cont	ribute to t	he cause of death?
(0 %	uld h	ed						1 □ Y	es 2 🗆 No	3 Prot	pably 4 Unknown
ords aquires	9 0	e e								Vere auto	ppsy findings available
ecords law requires	S CI	٥						24a. Was a	SV I		
- Re la	has ye 2	Somp						autop	med?	death?	mpletion of cause of 2□ No
_ (ate has	Be Completed	25. Was case referred to medical examiner?			26. P	lace of Death	autop	med?	death?	
Vital	ate has	To Be	examiner? 1 Yes 2 No	Hospital: 1 □ Ing		nt 3 DOA Other: 4	Nursing Ho	autop perfor 1 ☐ Yes n (Check only or me 5 at Resid	med? 2DNo 1	death?	2 No
n of Vital	fler this certificate has ineral director, page 2	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending	28a. Date of (Month,		of 28c. Injury at Work?	Nursing Ho	autop: perfor 1 Yes	med? 2DNo 1	death?	2 No
n of Vital	fler this certificate has ineral director, page 2	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending 2 Accident investiga 3 Suicide 6 Could no	28a. Date of (Month, atton	Injury 28b. Time of Injury	of 3 DOA Other: 4 Doal of 28c. Injury at Work? M 1 Yes 2	Nursing Ho	autop perfor 1 Yes n (Check only or residue) The Say Residue 28d. Describe h	med? 2 No 1 ence 6 Oth ow injury occurr	death?	2□ No (y)
n of Vital	fler this certificate has ineral director, page 2	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigations	28a. Date of (Month, atton		of 3 DOA Other: 4 Doal of 28c. Injury at Work? M 1 Yes 2	Nursing Ho	autop perfor 1 Yes n (Check only or residue) The Say Residue 28d. Describe h	med? 2 No 1 ence 6 Oth ow injury occurs	death?	2 No
n of Vital	fler this certificate has ineral director, page 2	Certification: To Be	examiner? 27. Manner of Death 1 Naturaf 2 Accident 3 Suicide 6 Could ned to the country of the	28a. Place of building	Injury , Day Year) 28b. Time of Injury of Injury - At home, farm, st g, etc. (Specify)	nt 3 DOA Other: 4 of 28c Injury at Work? M 1 Yes 2 reet, factory, office	Nursing Ho	autop perfor 1 Yes 1 Check only or me 5 Resid 28d. Describe h 28f. Location (S City or Tow	med? 2 No ne) ence 6 Oth ow injury occurr itreet and Numb m, State)	death? Yes er (Special red	2□ No
n of Vital	fler this certificate has ineral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying	28a. Date of (Month, ation of be ned 28e. Place of building	Injury Day Year) 28b. Time of Injury of Injury - At home, farm, sig, etc. (Specify) post of my knowledge, dealists of examination and/or in	of 3 DOA Other: 4 Doal of 28c. Injury at Work? M 1 Yes 2	Nursing Ho	autopperfor 1 Yes	med? 2 No ence 6 Oth ow injury occurs treet and Numb n, State)	death? Yes er (Special er or Runa	2□ No fy) al Route Number,
n of Vital	fler this certificate has ineral director, page 2	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending investigation of Pending investi	28a. Date of (Month, ation of be ned 28e. Place of building g Physicien: To the backgraminer: On the backgraminer:	Injury Day Year) 28b. Time of Injury of Injury - At home, farm, sig, etc. (Specify) post of my knowledge, dealists of examination and/or in	of 28c. Injury at Work? M 1 Yes 2 reet, factory, office	Nursing Ho	autopperformed autopperformed services autoperformed services autope	med? 2 No ence 6 Oth ow injury occurs treet and Numb n, State)	er (Special red	2☐ No All Route Number, stated. o the cause(s)
of Vital Physicien:	fler this certificate has ineral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending investiga 3 Suicide 4 Homicide 6 Could not determing 29a. Certifier (Check only one) Control Office Not the County of Check only one)	28a. Date of (Month, ation of be ned 28e. Place of building g Physicien: To the backgraminer: On the backgraminer:	Injury Day Year) 28b. Time of Injury of Injury - At home, farm, sig, etc. (Specify) post of my knowledge, dealists of examination and/or in	nt 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes 2 reet, factory, office	Nursing Ho	autopperformed autopperformed services autoperformed services autope	med? 2 No ence ence 6 Oth ow injury occurr itreet and Numb m, State) ause(s) and ma date and place, 29d. Date signed	er (Special red and due to the following of the following	2□ No al Route Number, stated. o the cause(s) Day, Year)
n of Vital	fler this certificate has ineral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending investiga 3 Suicide 4 Homicide 6 Could not determing 29a. Certifier (Check only one) Control Office Not the County of Check only one)	28a. Date of (Month, ation of be ned 28e. Place of building g Physicien: To the be and manner	Injury Day Year) Injury - At home, farm, sig, etc. (Specify) Dest of my knowledge, dealist of examination and/or in stated.	nt 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes 2 reet, factory, office th occurred at the time, data overstigation, in my opinion, 29c. License numb 2 2	Nursing Ho	autopperformed autopperformed services autoperformed services autope	med? 2 No ence ence 6 Oth ow injury occurr itreet and Numb m, State) ause(s) and ma date and place, 29d. Date signed	er (Special red and due to the following of the following	2□ No al Route Number, stated. o the cause(s) Day, Year)
n of Vital	fler this certificate has ineral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending investigates 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medicel E	28a. Date of (Month, ation of be ned 28e. Place of building g Physicien: To the be and manner	Injury Day Year) Injury - At home, farm, sig, etc. (Specify) Dest of my knowledge, dealist of examination and/or in stated.	nt 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes 2 reet, factory, office th occurred at the time, data overstigation, in my opinion, 29c. License numb 2 2	Nursing Ho	autopperformed autopperformed services autoperformed services autope	med? 2 No ence ence 6 Oth ow injury occurr itreet and Numb m, State) ause(s) and ma date and place, 29d. Date signed	er (Special red and due to the following of the following	2☐ No All Route Number, stated. o the cause(s)
Division of Vital To the Hospital or Attending Physician: within 24 hours after death.	fler this certificate has ineral director, page 2	Medical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending investigates 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medicel E	28a. Date of (Month, ation of be ned 28e. Place of building g Physicien: To the baxaminer: On the baxaminer and manne	Injury Day Year) Injury - At home, farm, sig, etc. (Specify) Dest of my knowledge, dealist of examination and/or in stated.	nt 3 DOA Other: 4 of 28c. Injury at Work? M 1 Yes 2 reet, factory, office th occurred at the time, data overstigation, in my opinion, 29c. License numb 2 2	Nursing Ho	autopperformed autopperformed services autoperformed services autope	med? 2 No ence ence 6 Oth ow injury occurr itreet and Numb m, State) ause(s) and ma date and place, 29d. Date signed	er (Special red and due to the following of the following	2□ No al Route Number, stated. o the cause(s) Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 10:00A Mary Elizabeth Peal <u> April</u> 2006 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Heritage Harbour Health & Rehab. Cntr Annapolis Anne Arundel 8. Date of Birth (Month, Dey, Feb. 3, Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🖺 F 102 Yrs. Feb. 1904 Pennsylvania Director 220 34 3174 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State ehow in then "natural", or iteme 23a or 28a-f ebovithe Medical Examiner must be notified at 1 ☐ Yes 2√ No Maryland Anne Arundel Davidsonville Directo 10g. Citizen of What Country? 10e. Street and Number 671 Discovery Court 21035 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💽 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 **Home** of Health and Mental Hygin Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Wesley Macklem Jennie E. Wilkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Slye 671 Discovery Ct. Davidsonville, Maryland 21035 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite cemetery, crematory or other place)
Kalas Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4-3-2006 Edgewater, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fundament 2973 Solomons Island Road Edgewater, MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to infimoviate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit physicien and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 Yo
9 Unknown 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 □ Yes 2 □ No 3 Probably Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 25. Was case referred to medical examiner? Be 26 Place of Death (Check only one) Other: Hospital: 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Tursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28d. Describe how injury occurred 27. Mapher of D 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? After or Attending 1 Natura 2 Accident 5 Pending after death.
I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel I Hospitel 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and Mile of certifier 30. Name and address of person 1CHARD 31. Date filed (Month, Day, 32, Registrar's Signature Year) APR 05 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg No. U h Certificate of Death 2. Date of Death Year

1 - For State Registrar I. Decedent's Name (First, Middle, Last) Day Month **Physician IRENE** ROHRER 13, 2006 4c. County of Death APRII /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner REEDERS MEMORIAL HOME WASHINGTON **BOONSBORO** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🔀 F Yrs. Director 219-74-4320 57 APRIL 21,1948 Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 28a-f show Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e 141 SOUTH MAIN STREET 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced "netural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HANDICAPPED HANDICAPPED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F VICTOR DAGENHART MARY HELEN ROHRER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: if item 27 is eny injury or other tre once. 19415 PORTERSTOWN ROAD, KEEDYSVILLE, MD ELSIE COOPER/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (2pacify) BRIAR CEMETERY 04/18/2006 KEEDYSVILLE, MARYLAND MT. 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Ke curver! burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien for use as the burial Box 68760 certificate be Physiclan/Medical use as the IF FEMALE:

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

23b. Was decedent pregnant

9 🗆 Unknown

in the past 12 months?

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Onknown

Year Day

Approximate Interval Between Onset and Death

9:45A.M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

MARYLAND

WHITE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

lisocder.

autopsy performed 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 No 1 Yes 26. Place of Death (Check only one)

2□ No

25. Was case referred to medical examiner? Other: 1 Yes 2 No 1 🗌 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

00062223 04

06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. PRAVEEN 31. Date filed (Month, Day, Year)

APR 1 4 2006 340 MILL ST., HAGERSTOWN, MD 21740 PRAVEEN BOLARUM. 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

KOHKER,

P.O. 1

Division of Vital Records,

Hospitel or Attending Physicien:

To the Hospitei or Attendir within 24 hours after death. To the Funeral Director; Al

After

the

þ

þ

Completed

Jo

Certification:

Medical

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistramEND#24a&b, perMD, 4/13/06, DPS, McCo Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 William Edward Robinson, **Physician** April 2, 6:30 рМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care- Bethesda Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1**⅓**M 2□F Days Months Hours 434-68-8111 62rs. Sept. 27, 1943 New York Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County wor mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar bartment of Health and Mental Hygiene. contant: if item 27 ie marked other than "neturel", or Iteme 23a or 28a-1 ehow contant: if item 27 ie marked other than "neturel", or Iteme 23a or 28a-1 ehow injury or other treumatic event, Ita Medical Examinar must be notified at a. 1 Yes 2 No Directo Maryland Montgomery Takoma Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7409 Maple Avenue 20912 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Marned altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates: 1966-70 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Personnel Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Edward Robinson Mary O'Neil Clifford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Jean Goter Robinson/ Wife 7409 Maple Avenue, Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition April 8, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 Alexandria, Virginia Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Dunkun 236. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Glioblastoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ þ 1 Yes 2 No 3 Probably 4 Unknown should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe 1X Yes 2□ No 1 XYes 2 10 No Division of Vital To the Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined efter 4 Homicide ā within 24 hours eft To the Funeral Di completely filled in 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

1211

29b. Signature and title of certifier

P.O.

30. Name and add person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar, M.D 9715 Medical Center Drive, #201, Rockville, MD 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) 10 2006

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

H0005128

29d. Date signed (Month, Day, Year)

April 4, 2006

State Registrar and manner stated

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5, NICHOLSON REILLY APRIL 6:20 A Μ. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL MONTGOMERY OLNEY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Year 1 ☐ M 2 💢 F Yrs. JAN. 1925 PÁ. 81 209-18-0405 6, Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28s-f ahow the Medical Exeminent must be notified at 1♥Yes 2□No Director SANDY SPRING MD. MONTGOMERY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20860 U.S.A. 18131 SLADE SCHOOL RD. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 I Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natu any injugy of ther traumaits." Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME injury or other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be COOK PETER REID NICHOLSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COLLEEN R. NOLAND/DAUGHTER 3525 SINGERS GLEN DR., OLNEY, MD. 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS - CREMATORY 4-7-2006 RIVERDALE, MD. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Licensee Munda M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physicien and the for use as the buriel-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No certificate 1 ☐ Yes 2 X No il or Attending Physician: after death. I Director: Atter this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۲ 1- Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation М 1 Yes 2 No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital c within 24 hours aft To the Funerel Di 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert lier 29c. License number acquier D39793 APRIL 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 PRINCE PHILIP DR., OLNEY, MD. 20832 CHRISTOPHER J. MAYS, M.D. 31. Date liled (Month, Day, Year) 32 Registrar's Signature State 10 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Yeer 5:30 P M Margaret E. Rutkoski April 4, 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Health and Rehab. Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 1, 1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 215-58-7611 96 Yrs. Director Washington, DC Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show ?7 is marked other then "natural", or items 23a or 28a-f shov treumatic event, the Medical Examinar must be notified at Funeral Director 1 ☐ Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 207 Timberwood Avenue 20901 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or item ony injury peotity treumatic event, its Medical Ferrance 1 ☐ Never Married 2 ☐ Married Specify.White Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 ☐ No Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Lansdown Flosie Lumsden 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George Rutkoski/ Son 207 Timberwood Avenue, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 1

Burial 2

Cremation 3

Removal from State Burtansville Union Cemetery 4 □ Donation 5 □ Other (Specify) 2006 Burtonsville, Maryland 21. Signature of Funegal Service Licenses 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 2090 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pulmonary Embolus 1 Hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence oi). physicien and s the burial-transit The law requires that the death certificate be executed Cerebral Infarction 30 Days Due to (or as a consequence of): Box 68760. 28 esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, MRSA Infection, Deep Venous Thrombosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X 3Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has certificate 1 ☐ Yes 2 ☐ No rs after deau... rai Director: After this ceruin... 1 ☐ Yes 2 X No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral i
completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61417 April 5, 2006 ND ghenre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johanna Fifi, M.D. 10 Center Drive, MSC 1063, Bldg. 10, Rm. B1D733, Bethesda, MD 31. Date filed (Month, Day, Year) **∦**egistrar's Signature State 10 2006 Registrar

		State of Maryland / Department of Healt		-	•	10000
		1 - State		, ,	2000	13009
		1. Decedent's Name (First, Middle, Last)		2. Date of Death	g. No.	3. Time of Death
Physic		Walter W. Ristow		Month April 3	Day Year . 2006	9:45 a M
/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat		mpili J	4c. County of Death	
		10450 Lottsford Road, #4115 Mitchellvi	11e		Prince G	eorge's
Funeral		Months Days Hou	nder 24 Hrs. ours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign
Director		071-20-7117 124 97 Yrs. Usual Residence of Decedent		April 20), 1908 Wi	sconsin
land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Mary 1-f sh	ţ	Maryland Prince George's Mitchellville				1 ☐ Yes 2 🛣 No
th the	irec	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Cou	untry?
itid Z I Z I 300030 be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or items 23e or 28e-f show event, I're Mcdical Examinat must be notilised at	Funeral Director	10450 Lottsford Road, #4115 20721		1	U.S.A.	
tams	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanie If Yes, specify Cuban, Me:	ic Origin? (Spec exican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Amer Black, White	
rs afte		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Spe 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	ecify:		Specify: Wh	ite
2 hours	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation		1	6b. Kind of Business/I	
hin 72 Med	piet	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	most of workin	g		,
ad with	E C	5+ Geographer			Library o	f Congress
be file doth	Be (17. Father's Name (First, Middle, Last)	Mother's Name	(First, Middle, M	laiden Surname)	
ould Men Men Marke	ပု		milie H			
perillicie; Mai yidilid 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No. 2012)			-	
1 and 1 and Healti ther t		Steve Ristow - Son 312 West Columbs 20a. Method of Disposition 20b. Place of Disposition (Name of			LS Church, Oc. Location - City or 1	
ages nt of t: With		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	l I			
Deficiency Definit. Pages Department of mportant: If it any injury or o		'4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 21. Signature of Euneral Service Licensee 22. Name and Address of F				. Virginia
Dermi Depa Impo any it		A Constance Basch 4739 Baltimon				
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	200	628		Onset and Death
/Medical		resulting in death) Due to (or as a consequence of):				- There are
Examiner	l.	Sequentially list conditions, b.				
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
xecut and	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
VICAL INECCIOUS, F.C. BOX 00/00, sicien: The law requires that the death certificate be executed certificate has been signed by the ettending physician and rector, page 2 should be detached for use as the burial-transit	calE	d				
g phy as the	100000					
h cert endin	M/UK	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deli	
o death	sicis	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
The law requires that the death certifica The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as it	Physician/Med	9 Unknown	D1	20a Did tab		the course of death?
ires the signe	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	rаπ I.		acco use contribute to s 2 ⊞¶o 3 ☐ Pro	bably 4 Dünknown
w requires:	Completed					
has ge 2 s	I dr			24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
VICIAN: The ician: The certificate ector, page	e Co	25. Was case referred to medical 28.	Di	1 Yes 2	□No 1 ☐ Yes	2 No
OI VICA Physician: rthis certific ral director,	o Be	evaminer?		(Check only one	nce 6 Other (Spec	i6a)
	I	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		8d. Describe how		ny)
Attending or death. ector: After by the fune	atio	2 Accident investigation M 1 Yes	2 🗆 No			
ir Atts	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
urs af	O					
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	ate and place, a n, death occurre	nd due to the ca id at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Med	29b. Signature and title of certifier 29c. License num		29	d. Date signed (Month	, Day, Year)
F 3 F 5		D 20			4/3/20	
(20)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1	0
		Don W. Yoblanowsky, mo byto y Executive	- Plan	e, Ly	them pr	3.
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature 3				
Regist	rar	APR 0 6 2006				

			For State Registrer	State of Maryland		nent of H cate of L		ntal Hygier Reg. t	Z 11116	13010
			Decedent's Name (First, Middle, Last)				2	Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Calvin Mace R	obbins				4 5	06	6636 M
	Examin		4a. Fapility Neme (If not institution, give sti	1 Medies Co	NKU	5/4	Location of Death		4c. County of Death	1100
	Funeral Director		214-07-8023	7. Age (In yrs. la		Inder 1 Year nths Days		Date of Birth (Month, Day, Yea)	1912 Ma	place (State or Foreign ntry) ryland
1	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	n				10d. Inside City Limits
1	Marylan -fehow	tor	MD Dorchest	er		Camb	ridge			1 Yes 2 □ No
Z	ith the M or 28e-f	Director	10e. Street and Number		10	of. Zip Code		10g.	Citizen of What Cou	intry?
Se	23a c		1305 Stone Bounda				1613		USA	tdi
0	tems	Funeral	11, Wanta States	2. Was Decedent Ever in U.S Armed Forces?	i. 13. Was	Decedent of H , specify Cuba	ispanic Origin? (Speci in, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
Calvin Robins Baltimore, Maryland 21215-0036	bs 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "nature!, or items 23a or 28e-1 ehou tiem 27 is marked other than "nature! can include the national can be not lifted at other traumatic event, the Marical Examinar must be not lifted at	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: WW I		es 2⊠No	Specify:	100	Specify: wh	
م <u>ن</u>	natu	ete	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Decedent's (Give kind iife DO N	: Usual Occup of work done : !OT use retired	during most of working		, Kind of Business/li	ndustry
72	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ıck dri	•		beverage	mfq.
25 b	Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name (
25 <u>F</u>	uid be Aenta rked tic ev	To B	Richard P. Robbi	.ns			Ada Tyl			
ary	2 sho and h Is me	Ü	19a. Informant's Name/Relationship (Typ				and Number or Rural i			
∑ ~	and lealth m 27 her tr		Donna R. Bramble	daughter	1617 Ta		Island Rd.		rd, MD 2 Location - City or 3	1677 Town, State
V.\ Pore	iges 1 of of H or of		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Re	moval from State	metery, cremator	y or other plac	ce)			
اماما haltimore,	permit. Pages Department of Important: If It eny injury or o		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License		: New Mai	rket Ce me and Addre			st New Ma ral Home	
B C	permit. Departr Importa eny inje		P-KBS				St., Camb			r.A.
	Physician /Medical Examiner	20	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	e cause on each line.	o view Am	. 0	multiple			Approximate Interval Between Onset and Death 2
18760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Oue to (or as a consequ	H	RF				
.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate hes been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ect	opic pregnanc ner (specify)	у		23d. Date of deli Month	very Day Year
ds, P	uires that signed b Id be deta	b	Part II. Other significent conditions con	tributing to death but not resu	Ilting in the under	lying cause giv	ven in Part J.			the cause of death?
Division of Vital Records, P.O.	: The law require cate hes been si , page 2 should t	Completed		CAS				24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
<u></u>	ician: Th certificate rector, pag		25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2 ☐ (Check only one)	MO IL Tes	2 No
₹	nysician: nis certifica director, p	To Be	avaminor?	ospital:	ER/Outpatient 3	DOA Ott	nor		e 6 Other (Spec	cify)
10	ding Phy h. After thi funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	rk?	Bd. Describe how		
io	ttendin death. ctor: Afr / the fur	atlo	2 Accident investigation	413/06		M 1]Yes 2 ⊠No		un step.	
ĕ	r Atter de lirecte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street,	factory, office			at and Number or Ru State)	
۵	pital t	Ce	29a. Certifier 1 Certifying Phys	howe icien: To the best of my know	wledge death co	nurrari at the t			Bounday (se(s) and manner as	
	24 hos	Medical	(Check only 2 Medical Exemination one)	ner: On the basis of examinal and manner stated.	tion and/or invest	igation, in my	opinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and tifle of certifier			29c. Licen		29d.	. Date signed (Mont	h, Day, Year)
	- >- 0) (db)			1+50	497		415/06	
			30. Name and address of person who co							
			Chris Snyder 1	OOE. Carrol	st. SA	rlisbur	y, md. 218	701		
4	St Regist	ate trar	31. Date filed (Month, Day, Year)	2006 32. Registrar's Signa	K A	mente	_			

			i icasc	State of Maryla	nd / Dan	artmon	t of H	alth a	nd M	ental Hyd	niene			
		4	For State	State of Maryla		rtificat			II (CI IVI			2006	120	7 1
			Registrar	1		lilicali	e oi L	Galli		2. Date of Dea	Reg. No.	.000	3. Time of	Death
	Physicia		1. Decedent's Name (First, Middle, Lass							April	Day	2006	1344	М
,	/Medic	al -	Rhoda Catheri 4a. Facility Name (If not institution, give			4h City	Town or I	Location o	f Death	April	4c. (County of Death		
	Examin	er	2050 Gillis Fal				oodb					Carro]		
	Formul		5. Social Security Number 6. Se		rs. last birthday)	If Under	1 Year	If Under 2		8. Date of Birth	h Vaarl	9. Birth	place (State of	r Foreign
	Funeral Director			□M 2 K F	77 Yrs.	Months	Days	Hours	Min.	Nov. 29	19	28 Mar	yland	
			Usual Residence of Decedent										10d Inside Cit	h. Limita
	how		10a. State 10b. County		City, Town or Lo Woodbi								10d. Inside Cit 1 ☐ Yes	
	8a-1	5	MD Carro	<u>T</u> T	MOOCIDI						10- 014	en of What Co		
	with the	Director	10e. Street and Number 2050 Gillis Fa	lla Poad		10f. Zip	Code	2179	7			ted Sta	•	
	ours after deeth with the Maryland set, or items 23e or 28s-1 ehow Examiner must be mailien at	Funeral		12. Was Decedent Ever in	ILS 13	Was Dece	dent of His			cify Yes or No-		4. Race - Ame		
		Į.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 (CXNo	į.				Puèrto I	city Yes or No- Rican, etc.)		Black, White		
920	urs af	by	3€XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2LXNo	Specify:				Specify:	White	
Õ	filed within 72 hours after Hygiene. other then "natural", or ite ent, the Medical Exemina	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usua kind of wo	al Occupa	ition uring most	t of workii	ng	16b. Kir	nd of Business/	ndustry	
2	ithin 19	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT u	se retired))				la-		
2	be filed within stal Hygiene. ed other then ' event, It e Ma		12th			HOIII	emake		r's Name	(First, Middle,	Maiden	own ho	one	
and	e d la b ●	Be	17. Father's Name (First, Middle, Last)	an Etrono						lizabet				
$\frac{8}{5}$	2 should be and Mental Is marked o	2	Raymond Clift		19b Maili	ing Address	(Street a					Town, State, Z	(ip Code)	
Maryland 21215-0036	C) (0 = 6		Francine Dorsey			5 Day				Woodbir			e de la companion de la compan	
	ges 1 end t of Health If Item 27 or other tr	1	20a. Method of Disposition		p. Place of Disponentery, cre	osition (Na	me of			ate	20c. Lo	cation - City or		
ē	M O - L		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		lorgan C				Apr	il 5, 1	006	Woodbir	ne, MD	
Baltimore,	permit. Page Depertment (Importent: If eny injury or once.		21. Sign vur of Funeral Service Lie		2	2. Name a	nd Addres	s of Facilit	y	al IIama	0 0	\	DA	
ñ	E G E G	8	Janua C	RUY	1	urrie 212 W	r-Que	een r d Lib	uner ertv	Road W	≀ ∝ (⁄infi	remator eld, M	21784	
			23a. Part 1 Enter the disease, or comp	olications that caused the d	eath. Do not en	ter the mod	de of dying	g, such as	cardiac c	or respiratory ai	rest,	,	Approximate Interval Bet	e ween
	Physician		Immediate Cause (Final di ea or condition	ASCUD									Onset and I	Jeath •
1	/Medical		relating in death)	ue to (or as a con:	sequence of):								1	-
	Examiner		Sequentially list conditions,	b. ————————————————————————————————————										
	D ==	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con:	sequence of):									
	ecute and -trans	cam	that initiated events resulting in death) Last	cDue to (or as a con:	sequence of):									
760,	res that the death certificate be executed igned by the ettending physician and be detached for use as the burial-transit	cal E)		240 10 (01 45 4 0011	304443130 317.									
687	physi the b		•	d										
×	ding se as	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pre							2	23d. Date of del	ivery	
Box	leath etter for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		□Ectopic p □ Other (s						Month	Day '	Year
Р. О.	the c by the ached	hysi	9 Unknown	9□ Unknown							_			
ď.	s that	y P	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying	cause give	en in Part I	١.	23e. Did t		se contribute to		_
p	w require been sig should b	P P								1 🗆 '	Yes 2	□No 3□Pr	obably 4 21	Jnknown
S S	awre	plet								24a. Was	DSV	prior to	itopsy findings completion of c	
Ĕ	The I	Completed								perfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes	2□ No	
ita	sician: The law certificete hes b irector, page 2 s	Be	25. Was case referred to medical examiner?				Lau		e of Deat	h (Check only o	one)			
× ×	hysic this co	2	Yes 2□ No		2 ER/Outpatie			4 🗆 140				5 ☐Other (Spe	cify)	
ū	After t	on:	27. Manner of Death 1 ► Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	or M	28c. Injun Work	γαι k? Yes 2.∐		28d. Describe	now mjui	y occurred		
sio	ttend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not b		At home farm s			163 2 🗆		28f. Location (Street an	d Number or R	ural Route Nun	nber,
Division of Vital Records,	or A efter Direct in by	Certification:	4 Homicide determined	building, etc. (Sp		ilicot, idoto	19, 011100			City or To				
_	To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours effer death. To the Funeral Director: After this certificate hes been signed by the ettending phycompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, dea	ath occurred	d at the tin	ne, date ar	nd place,	and due to the	cause(s)	and manner a	s stated.	-)
	ne Ho 24 h ns Fu	Medical	(Check only one) Medical Exam	niner: On the basis of exar and manner stated.	nination and/or i	investigatio	n, in my o	pinion, dea	ath occur	red at the time,	date and	place, and due	to the cause(3)
	To the To the Comp	Σ	29b. Signature and title of certifier			29	c. License				29d. Da	te signed (Mont	h, Day, Year)	
	WIL		1 styl	\sim			1000	0519	24		Hori	15,0	1006	
	10		30. Name and address of person who	F			1	0 1	10.0	lanches	1.	MA 1	110-7	
			Hebet 1- Hew all 31. Date filed (Month, Day, Year)	32. Reginar's S		anch	05141	100	ĮV	auc ups	1 =	14.8)	110 /	
	St Regist	ate rar		2005	W.	Some	20							

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year April 12, 2006 10:20 a^M Elizabeth L. Randol /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Co. Mem. Hospital Oakland Garrett If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 TF Yrs. Director 082 22 0873 101 Mar 26, 1905 MD Usual Residence of Decedent with the Manyland 10a State 10b County 10c. City, Town or Location Item 27 is marked other than "naturel", or items 23s or 28e-f show other treumstic event, I've Madeal Examinst must be notified at 10d. Inside City Limits MD Garrett Grantsville Director 1XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours atter death a Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a any injury or other treumatic event, the Mudical Examitise mustal once. 891 Dorsey Hotel Rd. 21536 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White 3 ₩Widowed 4 □ Divorced Specify Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Herbert Leighton Maude Cale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara McIntire 280 Rock Lodge Rd McHenry, MD 21541 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Cumberland Crematory 4/14/06 Cumberland, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burdock-Durst FH undo ca 21 N. 2nd St. Oakland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician NEUMONIA disease or condition resulting in death) days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEART 210 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 3 No Hospital or Attending Physicien; 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient this 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAKLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 13 2006 Registrar

1 - For State Registrar

			Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death
	Physici /Medic		WILLIAM SYLVEST	ER REES	E SR			April	6, 200	6 1:30Am
	Examin	_	4a. Facility Name (If not institution, give street and	number)		4b. City, Town, o	r Location of Death	7	4c. County of D	eath
			Doctors Hospital			Lan	ham		Prince	George
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)
	Director		220-70-7744	48	Yrs.			Jan.26	,1958 W	ash, DC
	pus *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation				10d. Inside City Limits
	lanyla sho	5				_				1 XYes 2 ☐ No
	he N	Director	MD Prince Geor	:ge	L	aurel 10f. Zip Code		1	0g. Citizen of What	Country?
	with a or	급		amb Taua			.00	'		Country
	death with the Maryland me 23a or 28a-f show rmust be notified at	Funeral	12706 Silver Bir	Decedent Ever in 11 S	13 1	207		city Yes or No-	U.S.A.	merican Indian,
_	ter d	Ë	1 Never Married 2 Married 1 XV	Forces? 1980	-	Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Stack, W	hite, etc.
-020	within 72 hours after death with the Marylan jiene. rthen "naturel", or Iteme 23a or 28a-1 show the Madical Examinar must be notified at	þ	3 Widowed 4 Divorced If Yes	Give 1987	1	Yes 28 No	Specify:		Specify: B	lack
5	2 ho	ted	15. Decedent's Education		16a. Deced	lent's Usual Occup	pation		16b. Kind of Busine	ss/Industry
V	within 7 ene. then "r	Completed	(Specify only highest grade completed	ge (1-4or5+)			during most of worki	ng	Glenard	en Police
V	d wit	NO.	2		POT	ice Off			Depart	ment
2	be filed tal Hygi d other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name			
yiand	Ment Ment wrkec	ည	James E. Reese				Lelia	a R. Ja	ckson	
Mar	and and las mu		19a. Informant's Name/Relationship (Type, Print)			•	and Number or Rura			
_	and and n 27		Lolita G. Reese- Wi				r Birch		irel, MD	20 / 08
e Ce	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury o <u>cother traumatic</u> eny injury o <u>cother traumatic</u> en		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ Removal for	om State	ce of Dispo netery, cren	sition (Name of natory or other pla	ce)	ate	20c. Location - City	or Town, State
Ē	Pag ment ant:		4 □ Donation 5 □ Other (Specify)	MD ,		rans Ce			Crownsv:	ille, MD
Бант	epart sport sport ny inj		21. Signature of Funeral Service Licensee	ρ	1 22	. Name and Addre	ss of FacilitySno	wden F	uneral 1	Home, PA
Ц	80589	6	Court of	MACION						e, MD20850
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. on each line.	Do not ent	er the mode of dyli	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ernina	1 2	ung (Cources			Onset and Death
	/Medical		resulting in death)	to (or as a conseque	nce of):	1				
	Examiner		Sequentially list conditions, b.	espera	lory	fai	Luch			
26	D #	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a conseque	nce of)					
	ecute and -trans	Examiner	that initiated events c.	to (or as a conseque	non of):					
Ď,	be ex ician burial		July 2011	to (or as a consequen	1100 01).					
09/90	eath certificate be executed attending physician and for use as the burial-transit	clan/Medical	d							
	certificate iding phys ise as the	/Me	IF FEMALE: 23c. If yes	outcome of pregnanc	v				23d. Date of	dolaron
ğ	death te atten	cian	in the past 12 months?	ve birth 2 Fetal de regnant at time of dea	eath 3	Ectopic pregnance Other (specify) _	У		Month	Day Year
j.	ires that the de signed by the a l be detached (Physic		nknown						
7	law requires that the as been signed by th 2 should be detache	P	Part II. Other significant conditions contributing	to death but not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did tot	bacco use contribut	to the cause of death?
coras,	uires sign ld be	d by	condiany opati	ny				112 Ye	es 2 No 3 🗆	Probably 4 Unknown
Ö	w require been sig	lete	unconsoried I	rialectes				24a. Was a	n 24h Were	autopsy findings available
Ü	0 - 0	Completed	Malnutrition	2000000			-	autops	ned? prior death	to completion of cause of
VIIal K	iclen: Th certificate rector, pag	C	25. Was case referred to medical				26. Place of Death			es 20 No
		00	examiner?	Minpatient 2□EF	VOutpatien	t 3 DOA Ott	ner: 4 Nursing Ho			naciful
ö	ig Physiter this	. To	27. Manner of Death 28a. D	ate of Injury 2	8b. Time of		ry at		ow injury occurred	респу
DIVISION	E == =	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	Month, Day Year)	Intury		rk? Yes 2 □ No			
<u> </u>	Attendir death.	fice	3 Suicide 6 Could not be 28e. P	lace of Injury - At hom	e, farm, str	eet, factory, office				Rural Route Number,
5	el or s afte al Dir	Certification:	4 Homicide	uilding, etc. (Specify)				City or Towr	i, State)	
	ospit hours unera y fille		29a. Certifier Cartifying Physician: To	the best of my knowl	edge, death	occurred at the ti	me, date and place,	and due to the ca	ause(s) and manner	as stated.
	n 24 n 24 he Fu	Medical	(Check only 2 Madical Examinar: On the one)	ne basis of examinatio manner stated.	n and/or in	estigation, in my o	opinion, death occurr	ed at the time, d	ate and place, and	due to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Σ	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (M	onth, Day, Year)
	nD		Mehne Masses) A	nn		D05	0514	(116/06	
	7		30. Name and address of person who completed MEHRU MASTER, MISS 31. Date filed (Month, Day, Year) APR 1 1 2006	cause of death (Item 2	3a) (Type,	Print)	. *-	-		
	300		MEHRU MASTER, MIS	, 6570 KE	nilue	nth av	re, Sul	ediw,	Riverdal	0 MB 20737
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signatur	relf.	gover				-
	Regist	ar	APR 1 1 2006	MAUS .	- /	<u></u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene | | | 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Robert Raleigh 2006 April /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 213 Mainsail Drive Stevensville Queen Annes If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Director 059-18-9289 80 27, 1925 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location Item 27 ie marked other then "natural", or Items 23s or 28s-f ehow other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits MD Director Queen Annes 1 ☐ Yes XX No Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Mainsail Drive 21666 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates: White ۾ 3 Widowed 4 Divorced WWIT Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Deperment of Heelth and Mantal Hygiens Importents if Item 27 ie marked other the eny Injury or other traumatic event, Italy once. 5+ Physician Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Kenneth Raleigh Ruby Bunting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Raleigh (Wife) 213 Mainsail Drive, Stevensville, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 4-5-2006 Crownsville, MD 21. Signature of Funesal 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Tah 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between One et and Death Immediate Cause (Final disease or condition resulting in death) CANCER NOSTATE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2. No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificete 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one Hospital: 1 Inpatient 1 Yes 2000 Other: 4 Nursing Home SQ Residence 6 Other (Specify) ပို 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1/2 Natural thours after death.

**Suneral Director: After the filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours at the Funeral D mpletely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier, 2 29c. License number 29d, Date signed (Month, Day, Year) 08/18 ripleted cause of death (Item 23a) (Type, Print) JANLEY (atiz un sis audante) KINS 500 BEST 6 ATEllo

State Registrar

31. Date filed (Month, Day, Year)
APR 0 5



Records, P.O. Box 68760, Division of Vital

1 = For State Registrar		State of M	laryland		tment of F		and Me		ene 0 0 6		301	5
Physician	ne (First, Middle, Last,		Fager	Rudol	ph			Date of Death	_	ear OO	3. Time of De 9:50/	
/Medical Examiner 4a. Facility Name	(If not institution, give	street and number)	4	b. City, Town, o	r Location of		1111	4c. County of	Death		
	ton County	Hospita	1		Hag	erston	vn		Wash	ingt	on	
Funeral 5. Social Security			ge (In yrs. last		f Under 1 Year			. Date of Birth	9	. Birthpla	ce (State or F	Foreign
Director 218-40-4	116	M 2121F	63	Yrs.	Months Days	Hours	Min.	(Month, Day, anuary		Country Penn	_{v)} sylvan	nia
Usual Residence	T		1.0									
Moutan 10a. State	10b. County		10c. City, 1	Town or Loca	ion					100	I. Inside City	
Maryland	Washingto	on			Hager.	stown					1 ☐ Yes 2	: FO NO
Maryland 10e. Street and N					10f. Zip Code			10	g. Citizen of Wha	at Country	y?	
10a. State Maryland 10e. Street and Ni 18726 Me 11. Marital Status	sa Terrace					21742			U.S.A			
The death of the		12. Was Decedent Armed Forces	?	13. Wa	s Decedent of H es, specify Cuba	lispanic Orig an, Mexican,	jin? (Specif , Puerto Ric	ly Yes or No- can, etc.)	14. Race Black, \	Americar White, et		
bouns after hours	ried 2 Married 4 Divorced	1 ∐Yes 2 🕅 If Yes, Give Year or Dates:		1 [Yes 2X No	Specify:			Specify:	Whi	t 0	
A Moderal Margin 12 hours at a matural, or a matural, or a matural, or a matural by F lementary Sec.	15. Decedent's Edu			16a Deceder	t's Usual Occup	ation			6b. Kind of Busin			
Complete (Special Complete Com	cify only highest grad	e completed)		(Give kir	d of work done of NOT use retired	durina most	of working	'	db. Kind of busin	ies sy iniqu	stry	
Elementary/Sec	ondary (0-12)	College (1-4or	5+)	Histo	logy Ted	chnici	lan		He	alth		
□ 正工章 등 a. 17. Father's Name	(First, Middle, Last)					18. Mother	r's Name (F	First, Middle, M	aiden Sumame)			
	es W. Fage	r. Jr.				Ma	raner	rite R	Fleagle			
2 of the later and the later a	lame/Relationship (Ty		- 77	19b. Mailing	Address (Street				City or Town, Sta		ode)	
2 psh = Crozor F	. Rudolph	(Husban							Marylan			
D 一元 a 5 20a Method of Die			20b. Place	e of Dispositi					0c. Location - Cit			
1 ABurial 2	☐ Cremation 3 ☐ P 5 ☐ Other (Specify)	lemoval from State	, ,		emetery	(8)			Din 1 d	14-		7
무 교육원을 .	uneral Service License	90	112199		ame and Addres	ss of Facility			Ringgold is Funer			L
21. Signature of F	2-1-	Dais	MOIN						ırg, Mar			₹ 3
23a. Parti. Enter	the disease, or compli	ications that cause	d the death. [A	pproximate	
Immediate Cause	art failure. List only or (Final	ne cause on each i	ine.	A:	CI	į				Ir	nterval Between	en ath
/Medical disease or condition resulting in death		Due to (or as	a consequen	O(I)	dh	och				on	e du	LY_
Examiner	1	540 10 (01 40	u consequent	100 01).								1
Sequentially fist c if any, leading to cause. Enter Und Cause (Disease of	onditions,	Due to (or as	a consequen	ice of).								
Tany, leading to cause. Enter Und Cause. Clisease o that initiated even resulting in death)	r injury											
resulting in death)		Due to (or as	a consequen	ice of):								
certificate be executed continued to the		l										
Aled Aled												
TF FEMALE: 23b. Was deceded in the past 1:	ii pregnani	3c. If yes, outcome 1 ☐ Live birth			topic pregnancy				23d. Date of	delivery		
in the past 13	□No	4☐Pregnant a			her (specify)				Month	Da	ay Yea	ar
D het the d by the graph of the sign of t			-									
> and > rait ii. Other sight	ficant conditions cor	tributing to death t	out not resultin	ng in the unde	rlying cause give	en in Part I.		23e. Did toba	icco use contribu	te to the	cause of deat	th?
wrequires wrequires should be significant of the si	te 17700	andlal	th	tave	tion			1 4 Y 6s	2 □ No 3 □	Probab	ly 4 ∐Unk	known
ple 2 sh	avonic	Rencel	Fa	ilove	2		ĺ	24a. Was an	24b. Wer	e autops	y findings ava	ailable
			_					autopsy performe	ed? deat	h?	tetion of caus □ No	se oi
o 25. Was case refe examiner?	rred to medical					26. Place of	of Death /C	heck only one				
O TO SEE SEE SEE SEE SEE SEE SEE SEE SEE SE	100 H	lospital: 1 atio	ent 2 ER/	/Outpatient	3□ DOA Othe	er: 4 🗆 Nurs	sing Home	5 🗌 Residen	ce 6 Other (Specify)		
D & E E E 27. Mann of Dea	th 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28i	b. Time of Injury	28c. fnjury Work	at	280	I. Describe how	infury occurred			
Attended Attended Control of Cont	investigation			. ,		Yes 2 □ N	lo					
1 or Attending Parameter death. 1 or Attending Parameter death. 2	6 Could not be determined	28e. Pface of In building, et	jury - At home tc. (Specify)	, farm, street	factory, office		28f.	Location (Stre	et and Number o State)	r Rural R	oute Number	r,
Cer lled in all of		1							,			
To the Hospital or Attending Physician: To the Hospital or Attending Physician: To the Hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. To the Hours after death. To Accident. To A	1 ☐ Certifying Phys 2 ☐ Medical Examin	ier: On the basis o	or examination	dge, death of	curred at the tim	ne, date and pinion, death	place, and	due to the cau	ise(s) and manne	r as state	ed.	
one) Vigin by Signature and One)		and manner st	ated.									
29b. Signature and	THO AN AN	10 0	1 6	2/	29c. License	number	0111	290	d. Date signed (M	ionth, Da	y, Year)	/
Restri	1 Bull /9	W Deviso	wol Pl	45/01	an		043	59	Apri	11	9 200	26
30. Name and add	ress of person who co	mpleted cause of c	death (ftem 23	(Type, Pri	1 11		_/	n.d	19			
robert	Krull	1459 1	Tutare	00 17	1411	aring	TOW	1 /1/c	1 2/	14	7	
State 31. Date filed (Mon	th Day Year'	20/4	rar's Signature	-	- CCC	1-0-7	-10	, , ,			-	

			1 - For State Registrar	State of Ma	ryland				ealth ar D <i>eath</i>	nd Me	ental Hy	giene Reg. No	000	13	016
ì	Physici		Decedent's Name (First, Middle, Las GEORGE	HEN	RY		STER	LING			2. Date of De Month APRIL	eath Da	y Year 2006		me of Death
	/Medic Examin		4a. Facility Name (If not institution, give					Town, or	Location of	Death	AFKIL	40	. County of Dea	ıth	
	Funeral Director		5. Social Security Number 6. Security Number 261-54-5723	RFM 2∏E	(In yrs. la 67	rst birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	Min.	8. Date of Bi (Month, Da JAN	rth ay, Year)	9 Ri	tholace (S	tate or Foreign FLORID
	filed within 72 hours after death with the Maryland Hygiene. Sther then "natural", or items 23s or 28s-f show ent, It's Maulcal Examiner must be notified at	Funeral Director	10a. State 10b. County MD PRINCE G 10e. Street and Number			Town or Lo	HEI	GHTS c Code	and all and like				izen of What C	1 X	de City Limits
3036	be filed within 72 hours after death with the Marylan Hygiene. do ther then "natural; or items 23a or 28a-1 show event, It's Macilial Examiner must be notified at	by	505 OPUS AVENUE 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:		v	Was Dece f Yes, spe 1 ☐ Yes			n? (Spec Puerto R	cify Yes or No lican, etc.)		U.S.A. 14. Race - Am Black, Whi Specify:	te, etc.	an, ACK
Maryland 21215-0036	d within 72 h giene. er then "nett	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	-)	life. I	kind of w	ork done d ise retired,	luring most o	of workin	g	16b. K	ind of Business		
yland	o d a b	To Be C	17. Father's Name (First, Middle, Last) CHARLES MALCO						EU	GENI		BUR	Sumame)		
σ	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumetic once.		19a. Informant's Name/Relationship (7 ETHEL M. REDWOOD 20a. Method of Disposition 1 □ Burial 2 ⊠Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature Funeral Service Licenses	/FRIEND Removal from State	cer	14415 ace of Dispo metery, cren VERDAI	DOI sition (Na natory or E CR . Name a	BROOD me of other place EMATO and Addres	X LANE ORY 4	E BOW Da /10/ J.	VIE, MA 106 B. JE	ARYL. 20c. Lo RIVI	ERDALE, I S FUNER	721 Town, Sta MARYL CAL HO	AND DME
	nysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a LUNG C	ANCEF	Do not ent							MARYLAN	Appro	rimate Il Between and Death
,00	be executed ician and purial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. METAST. Due to (or as a c. Due to (or as a d	ASIS conseque	TO BR	AIN								
O. BOX 6	the death certifi y the attending p iched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	☐Fetal d	death 3□	Ectopic p						23d. Date of de Month	livery Day	Year
cords, P	The law requires that ite has been signed boage 2 should be deta	by	Part II. Other significant conditions co	entributing to death but	not result	ting in the ur	nderlying o	ause give	n in Part I.				se contribute to		
		Completed									24a. Was autor perfo	osv	prior to death?	utopsy find completion 2 1 No	ings available of cause of
on or vital	Ing Pny I. After this uneral d	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)		R/Outpatien 28b. Time of Injury	-	28c. Injury Work	r. 4 🗆 Nursi	ing Homi	Check only on the control of the con	dence	5 □Other (Spe y occurred	cify)	
=	i Site	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At hom (Specify)	ne, farm, stre		100			f. Location (S City or Tov		d Number or Ri)	ural Route	Number,
	o the hospitel or vithin 24 hours afte o the Funeral Dit completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of iner: On the basis of e and manner state	xaminatio	ledge, death on and/or inv	occurred	at the time , in my op	e, date and p inion, death	place, an occurred	d due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cau	ise(s)
\ -	within 2 within 2 complet	W	29b. Signature and with of certifier 30. Name and address of person who c	Ompleted cause of d	ath (Itam C	02a) (T '		: License	number)5819	82			e signed (Mont		2006
	Sta Registr		C. DONALD GEOR 31. Date filed (Month, Day, Year) APR 1 0 2006		01 но	OSPITA	,	IVE	CHEVE	RLY,	MARYI	AND	20785		

		•		State of Maryla	and / Depa		Health a	nd Mental Hy	_	6 30 7
			Decedent's Name (First, Middle, Last)		\			2. Date of De		3. Time of Death
	Physici /Medic		DORIS	Sou	DERS			Month C4	13	06 12.21AM
	Examin		4a. Facility Name (If not institution, give st	JURSING		R	AN DA	-LLSTOWA	Ur	HITIMORE
	Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	V.	rs. last birthday)	If Under 1 Ye Months Day		8. Date of Bir Min. (Month, Da June 2	th 19, Year) 3,1929	^{9.} Birthplace (State or Foreign Country) Maryland
	land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Many Fired	tor	Maryland Washing	ton	Hag	erstown				1⊠Yes 2□No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of \	What Country?
	s 23a	ral	1646 Woodland Way	2. Was Decedent Ever in	-116 12	Mas Donadant	21740	in? /Specify Ves or No	USA	e - American Indian,
	Item Item	-une	11. Marital Status 1 Never Married 2 Married	2. was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo	10.5.	If Yes, specify C	uban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	Bla	ck, White, etc.
920	72 hours after death with the Maryland netural', or Items 23a or 28e-f ehow iteal Examinar must be multified at	þ	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □X1	to Specify:		Specify	white
5-0	72 ho 'netur	Completed by	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use ret	cupation ne during most	of working	16b. Kind of B	usiness/Industry
121	within ene. then "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		bo nor use rei tician	irea)		self-em	nployed
d 2	be filed within 72 hours after death with the Marylar ital Hygiene. Id other then insturel; or Items 23a or 28e-f ehow other the Medical Examinations is be notified at	Be Co	17. Father's Name (First, Middle, Last)	0	Dead		18. Mother	r's Name (First, Middle		
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other then " freumetic event, the Mad	To B	Harold Kels	ner Snyder			Mar	y Louise S	houp	
lary	ges 1 and 2 should t of Health and Men If item 27 Is marke or other treumetic		19a. Informant's Name/Relationship (Typ	e, Print)				r or Rural Route Numb		
	l and tealth im 27 her tr		Deborah Campbell – 20a. Method of Disposition		The second secon	and the American State of the Control of the Contro		Hanover,		.7331 City or Town, State
20.	ages Int of H		1⊠ Burial 2 ☐ Cremation 3 ☐ Re	movai from State	b. Place of Dispo cemetery, cre reen Hi			4/15/06		oro, Penna.
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other tree		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			2. Name and Ad				
Ba	permit. Departi Import any inj		Scitt)	MI Kens	4	15 E. W:	ilson B	1vd., Hage:		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the decause on each line.	eath. Do not en	ter the mode of	tying, such as o	cardiac or respiratory a	rrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	1	117 hair	ieris	Diseas	e		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):					
1		-e	Sequentially list conditions, if any, leading to immediate	Due to (or as a con-	sequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
,092	te be execut ysician and le burial-trar		resulting in death) Last	Due to (or as a con-	sequence of):					
876	eath certificate be executed attending physician and for use as the burial-transit	dicai	_d							
89 X	certific iding p	/Me	IF FEMALE:	ic. If yes, outcome of pre	gnancy				23d. Da	te of delivery
Box	death atten	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		⊒Ectopic pregna ⊒ Other (s <i>pecify</i>				onth Day Year
P.0	that the de ed by the detached	hys	9 Unknown	9□ Unknown						
	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	ed by F	Part II. Other significant conditions con	ributing to death but not	resulting in the u	underlying cause	given in Part I.	111		tribute to the cause of death? 3 □ Probably 4 ☑Unknown
ဝ၁	e law re has bee je 2 sho	Completed						24a. Was	psv	Were autopsy findings available prior to completion of cause of
Ä	Th efe pag	Com						perfo 1 ☐ Yes		death? 1 ☐ Yes 2 ☐ No
Vita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				of Death (Check only		
of	Phys this ral dii	7: To	1 ☐ Yes 2 ☑ No 27. Manney of Death	ospital: 1 Inpatient : 28a. Date of Injury (Month, Day Yea.			ijury at Vork?	rsing Home 5 Res	how injury occur	
ion	Attending Phy or death. ector: After thi by the funeral	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury		Vork? ☐Yes 2☐N	No		
Division of Vital Records,	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp		reet, factory, offi	ce		(Street and Numb wn, State)	ber or Rural Route Number,
_	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my er: On the basis of exam and manner stated.	knowledge, dea nination and/or in	th occurred at th	e time, date and ny opinion, deat	d place, and due to the th occurred at the time,	cause(s) and madate and place,	anner as stated. and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lic	ense number			d (Month, Day, Year)
			Naun L. D	abrtt, M.T). 	D	00586	= 76	April	13,2006
			30. Name and address of person who co	mpleted cause of death ((Item 23a) (Type	, Print)	1 200	Rose and company	in M	D 21136
9F	ا- تـــ Sta	ate	Karen L. Balbint, 2	32. Registrar's S	ignature	2 , 3000		17131613		
	Regist		31. Date filed (Month, Day, Year)	32. Rogistrar's S	B. D.	ade				
					35					

					State of M	anyland	/ Dena	rtment of	Health and	Mental Liv	diene			
			1 - For State Registrar		GIALE UI IVI	arylanu		tificate of		-	Reg.(No	A 13 1	3	3018
			1. Decedent's Name	e (First, Middle, La	st)					2. Date of De	ath			3. Time of Death
	Physici		Paul Edw	in Smith						April	12 ^{Da}	200	Year 6	3:00 A M
	/Medic Examin		4a. Facility Name (I	f not institution, giv	e street and number)			4b. City, Town,	or Location of Deat	h	4c	. County o	f Death	
		10	RAVENWO	OD LUTHE	RAN VILLAG			HAGERST				ASHIN		
	Funeral		5. Social Security N 219-12-0		Sex 7. Ag	ge (In yrs. lasi 81	birthday) Yrs.	If Under 1 Yea Months Day			rth ay, Yea <i>r)</i>		9. Birthpli Count	ace (State or Foreigr ry)
	Director		Usual Residence of	, 10 .	X	01	115.			10/0//	1924	4		MD
iand	Mo #		10a. State	10b. County		10c. City, T	own or Lo	cation					10	d. Inside City Limits
Man	H H	to	MD	Washing	ton	Ha	igers							1. AYes 2 No
within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent, or Items 23a or 28a-f show Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiliar is wat he notified at 200ce.	Completed by Funeral Director	10e. Street and Nur 415 Mich	nigan Ave	nue			10f. Zip Code	21740		10g. Cit	tizen of Wi	at Count	ry?
death	ms 2	nera	11. Marital Status		12. Was Decedent		13. V	Vas Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	0-	14. Race		
after	or Ita	F.		ied 2 Married	Armed Forces: 1 X Yes 2 ☐ If Yes, Give	No		Tes, specify Cu I⊡ Yes 2 ⊠ N		to rican, etc.)		Specify:	, White, e T⊿7	hite
ours	- H	d by	3 Widowed	4 Divorced	If Yes, Give Year or Dates:	1943-4	6	163 200	o opecity.			<i>Зреспу</i> :	VV.	IIITCE
72 h	"netc	ete	(Spec	15. Decedent's E		1	(Give	lent's Usual Occ kind of work don	e during most of wo	rking	16b. K	ind of Bus	iness/Ind	ustry
ed within 72 hours af	than	du	Elementary/Seco	ndary (0-12)	College (1-4or	5+)		00 NOT use retir i two Swst	en Repai:	^	Fed	era1	Gove	ernment
l jed	Hygie ther int, th		17. Father's Name	(First, Middle, Last)		U CIII.	rcy byst		me (First, Middle	1			LIBROITO
d be	ental ced o	o Be		alopher S						Mae Roc			,	
Dermit. Pages 1 and 2 should be file	th and Me 7 Is mark treumati	2	19a. Informant's Na		Type, Print)				et and Number or Ri oridge Dri					
, a	Heali em 2 other		20a. Method of Disp			20b. Plac	e of Dispos	sition (Name of natory or other pi		Date	20c. L	ocation - C	ity or Tov	vn, State
ades	t: If it		1 XBurial 2		Removal from State	_		natory or other pi n Mem Pa		L4/2006	Нар	ersto	own .	MD
nit.	artme orten injur g.		21. Signature of FU		/	Occur			ress of Facility Ge					
90	Depar Impor any ir			3, 4		$\overline{}$			otomac Sti					
	E 18				plications that cause one cause on each l	d the death. I	Do not ente	er the mode of dy	ying, such as cardia	c or respiratory a				Approximate Interval Between Onset and Death
	ysician		Immediate Cause (disease or condition resulting in death)	(Final on	a. Mel	Mah		nuia	- Can	tut				y
	Medical xaminer		rooding in doding	(Due to (or as	a consequer	ice of):							
		7	Sequentially list co	nditions,	b. Due to lor as	a consuluer	ce off:							
pet	nsit	를	Sequentially list concause. Enter Under Cause (Disease or that initiated events	ertying injury										
e be executed	physician and s the burial-transit	Examiner	that initiated events resulting in death) I	•	C. Due to (or as	a consequer	ice of):							
te be ex	/sicia e bur	cal			d									
tificat	as th	ledi												
death certifica	attending phy I for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was deceden		23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnan	cv			23d. Date		•
deat	0 2	slcië	in the past 12 1 ☐ Yes 2 [□No	4□Pregnant a 9□Unknown			Other (specify)				Mont	h I	Day Year
The law requires that the d	ned by the a detached t	Phy	9 Unknown							on Did			1 . 4 - 4b	
es th	igned be del	by	Change Change		contributing to death t	out not resultin	_	iderlying cause o	jiven in Part I.			use contric		cause of death?
regui	teen si	eted		- Sewe	ucu .		7	27000				110	1 1000	loiy 4 Delikiloilii
sicien: The law requires 1	has t	nple								24a. Was		pri	ere autop or to corr ath?	sy findings available pletion of cause of
	cate , pag				,						2 40		Yes :	2 🗆 No
hysician:	rithis certificate has	Be	25. Was case refer examiner?		Hospital:			. [0	lthon .	ath (Check only		-		
hys	this al dir	2	1 Yes 2 2 27. Manner of Deat		i 1 □ Inpati		Outpatien b. Time of	t 3 ☐ DOA 28c. Inj	4 (ZLIMETSING F	Home 5 ☐ Resi 28d. Describe)
	Afte	tlon	1 4 Natural	5 Pending investigation	28a. Date of Inj (Month, Da	y Year)	Injury	W	ork? □Yes 2□No			,	-	
l or Attending	after death Director: / d in by the f	Certification	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In	jury - At home tc. (Specify)	, farm, str	eet, factory, offic		28f. Location (City or To			or Rural	Route Number,
Hospital or	unerel	Medical Ce	29a. Certifier (Check only one)		nysician: To the best miner: On the basis of and manner s	of examination								
운	n e p	Mec	29b. Signature and	title of certifier	and mainlef 5			29c. Lice	nse number		29d. Da	te signed	(Month, D	ey, Year)
o the Ho	ift i		3											
To the Ho	within 2. To the F			_tanta	mp			01	8019		ACA	121	2 2	2006
To the Ho	withi To 1 com		30 Name and add	-tout		death (Item 21	Ba) (Type		8019		ACA	رد (2,2	2006
H S To the Ho			30. Name and addr	ress of person who	completed cause of	death (Item 23	3a) (Type,	Print)	MAGER					

DHMH 17 Rev 1/2001

SMITH, Paul Edwin

			For State Registrar		State of	of Man			irtment of H tificate of I			lental Hy	gieņe Reg. Nô.	006)	13019
			Decedent's Name (First, II	fiddle, Las	st)							2. Date of De	eath			3. Time of Death
	Physici			PAU	IT.	SAN	SONE					Month APRIL	2 ,	2006	ar	5:35 P M
	/Medic Examin		4a. Facility Name (If not instr						4b. City, Town, or	Location	of Death	1		County of I		3,103
			SHADY GRO	JE AD	VENTIS'	T HOS	PITAL		ROCK	VILLI	Ε		M	ONTGO	MER	Y
	Funeral		5. Social Security Number	6. S		7. Age (I	In yrs. last bir		If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9.	Birthpla	ace (State or Foreign
	Director		579-34-3868		MM 2□F		76	Yrs.				MARCH :	28,19	30		Ĥ. D.C.
	and w		Usual Residence of Decede 10a, State 10b, Co			11	Oc. City, Tow	n or Lo	cation						10	d. Inside City Limits
	Aaryli reho	ō		NTGOM	EDV		•		THERSBUR	C						1 ☑ Yes 2 ☐ No
	28e-1	Director	MD . MO	NI GOP	IEKI			GAI	10f. Zip Code	<u>. </u>			10a, Citi	zen of Wha	t Count	rv?
	deeth with the Maryland me 23a or 28e-f ehow rmust be routiled at		9 CHEST	מוויי כ	יתי					0882				U.S.A		
	ne 2;	Funerai	11. Marital Status	NUI S	12. Was Dec		er in U.S.	13. \	Vas Decedent of H	ispanic O	rigin? (Sp	ecify Yes or N	0-	14. Race - A	America	
و			1 Never Married 2		Armed F 1 Tes If Yes, G	2 🔯 No			Yes, specify Cuba ☐ Yes 2☑ No	ın, Mexica Specifi		Hican, etc.)		Black, \ Specify:		
5-0036	within 72 hours after ene. then "netural", or Ite	d by	3 Widowed 4 Divo	rced	Year or I						<i>'</i>				WHI	
<u>7</u>	"netu	Completed	15. Dec (Specify only I	edent's Ed ighest gra)	16a.	(Give	lent's Usual Occup kind of work done of OO NOT use retired	during mo	st of work	ang	16b. Ki	nd of Busin	ess/Ind	ustry
12	within and the state of the sta	E G	Elementary/Secondary (0-	12)	College	(1-4or 5+)		iire. i	COMMUNIC	•	VIC.		Α.	C DE	т т	ASSOC.
N D	Hygie ther	e Co	12 17. Father's Name (First, Mi	ddle, Last))				COPEIDNIC			e (First, Middle			، بابا،	ABBOC.
Maryland	d be ental c av		PAU		SANS	ONE					G	LADYS	Н	IARWOR	тн	
\mathbf{Z}	should be nd Menta marked umaric av	F	19a. Informant's Name/Rela			01.12	196	. Mailir	g Address (Street	and Numi						Code)
	and 2 Balth a n 27 is		NOEL SANS	ONE/D	AUGHTE	R	2	22 E	USH HILL	CT.	, GAI	THERSBI	URG,	MD. 2	088	2
ē,	E Heg		20a. Method of Disposition		-	1	20b. Place of cemeter	f Dispo	sition (Name of natory or other place	(e)		Date	20c. Lo	cation - Cit	y or Tov	vn, State
Ë	Pages nent of I		1 ☐ Burial 2 🕅 Crema 4 ☐ Donation 5 ☐ Oth			n State		•	CREMATO	. 1	4-6-	2006	RI	VERDA	LE,	MD.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic as once.		21. Signature of Funeral Se	vice Licer	nsee	(11)	W00001	22	Name and Addre	ss of Faci	RAL H	OME & O	CREMA	TORIU	M,P	.A.
_	au z • u		23a, Part1, Enter the diseas	P OV COM	olication that		M00091		801 CLEV					E, MD		D/3/ Approximate
			shock, or heart failure.	List only	one cause on	each line.				.g, 50011 L	o our orac	or roopiratory t	211001,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	-	a		erre		110						-	
	Examiner				Due to	o (or as a c	consequence		copiro	1/00	. 7	Jail	020	-		
		ē	Sequentially list conditions, if any, leading to immediate		b. Due to	for as a c	опъедиелье		C 3 61 4 0	100	,7	9-11				
	be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1		No	est	vis	- Ne	act	-7	alla	16			
Ó	exec en an rial-tr	Exa	resulting in death) Last		Due to	o (or as a	sequence	of):						7		
8760	cate be executed physicien and the burial-transli	dical			o CN	JCA	116		postru	C+1	V.C.	NICE	1000	12)) 10 T	ar
9	ntifice ng pt		IF FEMALE:													
õ	ath ce trendi	an/I	23b. Was decedent pregnal in the past 12 months?			birth 2 [Fetal death		Ectopic pregnancy	,			1	23d. Date o Month		y Day Year
P.O. Box	The law requires thet the death certifi tie hes been signed by the ettending l bage 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Preg 9∐ Unk		ne of death	5[Other (specify) _							,
	res thet t igned by be detai	4	Part II. Other significant co	nditions o	contributing to	death but r	not resulting i	in the u	nderlying cause giv	en in Parl	tl.	23e. Did	tobacco u	se contribu	te to the	e cause of death?
g	quires n sigr ald be	d by	<u>qt</u>	via	1-1	ibi	1/16.	2 /	100			1 🗆	Yes 2	X40 3[] Proba	ibły 4 ∐Unknown
ဝွ	s been si	siete	Q	16 K	2001	, \2	J'I) T	91				24a. Wa		24b. Wer	e autop	sy findings available
æ	The law te hes age 2 s	Completed							1			auto perf	opsy ormed? 2 Q∤¶o	dea	th?	pletion of cause of
ā	ilcien: Th certificate rector, pag	0	25. Was case referred to m	edical				-		26. Pla	ce of Deat	th (Check only				
>	Physicien: r this certificatal director, i	To B	examiner?		Hospital:	npatient	2□ ER/O	utpatier	t 3 DOA Oth	er: 4 🗆 t	Nursing Ho	ome 5 🗆 Res	idence	6 Other (Specify)
0	ding Pl h. After th funeral		27. Manner of Death 1 Natural 5 P	ending	28a. Date (Mo	e of Injury onth, Day Y	'ear) 28b.	Time o Injury	Wor			28d. Describe	how injur	y occurred		
<u>s</u>	eath.	cati	2√☐ Accident in	vestigatio						Yes 2[]No		10:			
Division of Vital Records,	after of Direction by	Certification:		etermined	280. Plac	ding, etc. (r - At home, fa (Specify)	arm, sti	eet, factory, office				wn, State		or Hurai	Route Number,
_	spital nours neral filled		29a. Certifier 1	tifying Pt	hysician: To th	ne best of r	my knowledg	e, deat	occurred at the tir	ne, date a	and place,	and due to the	e cause(s)	and manne	er as sta	ited.
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	(Check only 2 Me one)	dical Exa	miner: On the	basis of ex inner state	xamination ar	nd/or in	vestigation, in my o	pinion, de	eath occur	red at the time	, date and	l place, and	due to	the cause(s)
	To the To the comp	ž	29b. Signature and title of c	ertifier	-Hn.				29c. Licens				29d. Dat	e signed (A	Month, E	Day, Year)
)			Mind	(20	(")				DI	711	5 2	MD	17	111	3	5001
	b		30. Name and address of po	rson who	completed car		th (Item 23a)	(Type,	Print)	1		0-	~ - 1	- C1.	8	ud scell
			31. Date filed (Month, Day,	Year	12	a o	Signatura	CI	(01) DV	11 46	. (26,06	de	CAN	0	IN SCOTA
	Sta Registr		APR	10	2006	MELLE	s Signature	A	BILL							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

SALLAD

2. Date of Death

Day

29d. Date signed (Month, Day, Year)

APRIL 7, 2006

Month

3. Time of Death

	Physici /Medic		FLOREN	VCE			5	CHF	1RF	F	APRI	L 7	20		826 PM
3	Examin		4a. Facility Name (If not institution, ga						Location of		-	4c.	County of D	eath	
			THE JOHNS HOP!	KINS HO	SPITAL	_			LWO		ity				
	Funeral		,	Sex 7.	Age (In yrs. la	ist birthday) Yrs.	Months	Days	If Under Hours	Min.	i. Date of Bir (Month, Da	ly, Year)		Country)	(State or Foreign
	Director		069-16-6435 Usual Residence of Decedent		83	113.				0	4/13/1	922	N	EW YO	RK
	iand w		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. lr	side City Limits
	Mary Fresh	ō	MARYLAND MONT	GOMERY				SILVI	ER SP	RING				1	X Yes 2 □ No
	r 28s	lrec	10e. Street and Number				10f. Zi	p Code				10g. Citi	zen of What	Country?	
	th wit	a	11105 NICHOLAS DR	IVE					2090				U.S.A	•	
	r dee	ner	11. Marital Status	12. Was Decede Armed Force		S. 13. V	Vas Dece f Yes, spe	edent of Hi	spanic Ori n, Mexicar	gin? (Spec n, Puerto Ri	fy Yes or No can, etc.))-	14. Race - A Black, V	merican In Vhite, etc.	dian,
36	be filed within 72 hours after deeth with the Maryland stal Hygiane. Identify than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Exarignar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date				2 ∏ No					Specify:	WHI	ГE
21215-0036	2 hou		15. Decedent's l	Education		16a. Deced	lent's Usi	Jal Occupa	ation			16b. Ki	nd of Busine	ss/Industry	,
212	hin 7.	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4	or 5+)	life. L	DO NOT	use retired	u <i>rin</i> g mos)	t of working	,				
2	filed wit Hygiane other tha	Son		3				SECRI	ETARY				GOVE	RNMEN'	Γ
2	be file d oth	0	17. Father's Name (First, Middle, Las								First, Middle	, Maiden	Sumame)		
<u>\S</u>	should be nd Mental marked of	၉	ISRAEL SHANDELMAN							IE LE		. 0:1	· T Ot-	7: 0: 1	-1
Maryland	12 sh h and h and 7 is m		19a. Informant's Name/Relationship LEON SCHARFF/HUSB				•				Route Numb ILVER				902
o,	Healt Healt em 2		20a. Method of Disposition			ace of Dispo	sition (Na	ume of	1	Da Da			cation - City		
altimore,	permit. Pages 1 end 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate	metery, cren HEBRO				4/10/	2006	FI IIS	HING,	NEU	A∪BK
₹	artme ortan injur		21. Signature of Funeral-Service Lic		rii.				s of Facili		2000	LEOD	IIING,	MEW	IONIX
B	Ded of the same		PRETER))		E	DWAR	D SAC	GEL F	UNERA	L DIRE	CTIO	N, IN	C.	D 20852
		-	23a Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	ised the death	. Do not ent	er the mo	de of dyin	g, such as	cardiac or	respiratory a	rrest,	. HIP. و نا	App	roximate rval Between
1	Physician		Immediate Cause (Final disease or condition		LTI	ORG	AN	FAT	TLU P	ζ C					et and Death
7	/Medical		resulting in death)		as a consequ		,,,	1 11/2		1 😀					
П	Examiner		Sequentially list conditions	ь. 5.	EPSI	5								1	MEEK
	D #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequ	ence of):									
	ecute end -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or	r as a consequ	ence of):									
60	eath certificate be executed attending physician end for use as the burial-transit	a E		500 (0)	as a consequ	orios or).									
Box 68760,	icate phys s the	odlo		d											
×	certif nding use a	ZW.	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnar	псу	-						23d. Date of	delivery	
Ö.	0 0	sician/Medical	in the past 12 months? 1 □ Yes 2 X No		h 2 ∐ Fetal ntat time of de		Dectopic Other (s	pregnancy s <i>pecify)</i>					Month	Day	Year
o.	at the by the	Phys	9 □ Unknown *								T				
_	res that th signed by to be detach	by	Part II. Other significant conditions	contributing to dea	th but not resu	Iting in the u	nderlying	cause give	en in Part I	l.					use of death?
ord D	w require been si should a	ted										Yes 2		Probably	
Records,	2 2 2	Completed									24a. Was auto perf		buot	to complet	indings availabte tion of cause of • .No
ita		BeC	25. Was case referred to medical						26. Place	e of Death	(Check only	_/_			
<u></u>	Physician; The raths cartificate har al director, page	Tof	examiner? 1 Tes 2 No	ER/Outpatien			4 NI	ursing Hom	e 5 🗆 Res	idence	6 □Other (Specify)			
ouc	ding h. After funer	Ë	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat		Injury Day Year)	28b. Time of Injury	M	28c. Injun Worl	yat k? Yes 2□		3d. Describe	how injur	y occurred		
Division of Vital	l or Attending after death. Director: Afte in by the fune	ertificatio	3 Suicide 6 Could not 4 Homicide determine	be 28e Place o	f Injury - At ho g, etc. (Specify	me, farm, str	eet, facto	ory, office		28	Bf. Location City or To			r Rural Rou	ite Number,

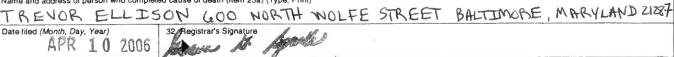
State Registrar 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 10 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last)



Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** MARCH Ž'6 2006 SIMPKINS 3:27 MATTIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 8. Date of Birth (Month, Day, Year) April 1 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Hours Months 1 □ M 2 🖾 F 1913 NORTH CAROLINA 92 579-32-9303 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f show r than "natural", or itsms 23a or 28a-f shorthe Medical Examiner must be notified at 1X Yes 2 No Director SEAT PLEASANT PRINCE GEORGE'S MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 U.S.A. 6210 FOOTE STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after all Hygiene.

Hygiene.

other than "natural", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify 9 BLACK 3 Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any jury or other traumatic svent once. Be SIMPKINS HARVARD THOMAS FANNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2411 GREELEY PLACE LANDOVER, MARYLAND MARY JONES/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

■ Burial 2

□ Cremation 3

□ Removal from State 4/4/2006 CLINTON, MARYLAND RESURRECTION CEME. 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Fhal disease or condition resulting in death)

ACUTE HEART FAILURE 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner HYPERTENSIVE CARDIOVASULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use as the burial-transit Attanding Physicien: The law requires that the death certificate be executed ATHEROSCLEROTIC VASULAR DISEASE Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 2X No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☒ No After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 9c. License number 29d. Date signed (Month, Day, Year) APRIL 3, 2006 WW D19459 ge 34. Name and addr ss of pirs in who completed cause of death (Item 23a) Type, Print) B FRANCYNE O. ANDERSON 6492 LANDOVER ROAD SUITE C LANDOVER MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Si State APR 0 6 2006 Registrar

			For State Ragistrar	State of Marylar	-	artment of F rtificate of			ene 0 0	6	13022
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		NEVA VIRGINIA STI			1		March 28	3, 2006		10:55 a ^M
)	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County		
			Shady Grove Adver			Rockv	IIIE If Under 24 Hrs.	8. Date of Birth	Montg		
Н	Funeral Director			□M 2\\ F 88	Yrs.	Months Days	Hours Min.	(Month, Day, June 14	Year) 1917		nce (State or Foreign y) Virginia
	D		Usual Residence of Decedent					Jule 14	, 1)1/		
	how	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10	d. Inside City Limits
	8a-1	Director	Maryland Prince (George's Gr	eenbe1						1 X Yes 2 No
	with th	ä	10e. Street and Number			10f. Zip Code			g. Citizen of W	hat Count	ry ?
	eath of	era	5M Gardenway	12. Was Decedent Ever in U	S 13	20770	lienanie Origin? (Spe		J.S.A.	e - America	n Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: if item 27 is marked other than "natural; or itema 23a or 28a-f ehow appringnty or other treumatic event, The Medical Examinar must be mulliad at ODGe.	by Funeral	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba	tispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		k, White, e	tc.
21215-0036	2 hou	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Bu	siness/Indu	ıstry
2	hin 7	Completed	(Specify only highest gra	College (1-4or 5+)	lite.	DO NOT use retired	during most of worki	ng			
7	or th	Son	12		Cosm	etologist			Teach		
lug	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	faiden Sumam	θ)	
Maryland	narke narke	ဥ	Denis Brown	Sur a Marian	405 14-10		Virginia			0	2-4-1
Mai	d 2 sh th and 7 is n treun		19a. Informant's Name/Relationship (1) Leslie Guy Halbri	• • • • • • • • • • • • • • • • • • • •		•	and Number or Rura				
ð,	1 en Heal tem 2		20a. Method of Disposition			nerre squa esition (Name of matory or other place	are Road,		Oc. Location -		
ᅙ	ages ant of t: if if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval moin state		matory or other plac can Cremato		/2006	Alexan	dria.	Virginia
Baltimore,	ortar		21. Signature of Fur gral Service Licen				ss of Facility Gas			-	_
ä	Page a		Valuis Treth	55 MO134	73 4	739 Balti	imore Ave.	, Hyatts	sville,	MD 2	0781
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the dear	th. Do not en	ter the mode of dyir	ng, such as cardiac o	or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Preumor	ria.						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):		,	1.			4
	Zaminer	_	Sequentially list conditions, if any, leading to immediate	Chronic ue to (or as a consec	290	tructiv	re Lune	disea	ase		Years
	pet nsit	Examiner	Cause (Disease or injury	00 to (or as a consec	juence on.						
	execunand and al-tra	xar	that initiated events resulting in death) Last	C. Due to (or as a consec	quence of):						
68760,	ificate be executed g physicien and as the burial-transit	edicai		d							
_	tificat ng phy as th	Medi	IS SECULIS								
ŏ	es that the death certifi igned by the ettending be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 Live birth 2 Feta		Ectopic pregnancy	,			e of deliver	•
P.O. Box	e dea the et ned fo	Sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnant at time of o	leath 5	Other (specify)			Mor	101 L	Day Year
	hat th	F.	Part II. Other significant conditions or	ontohuting to death but not res	sulting in the u	nderlying cause giv	en in Part I	23e Did tob	acco use contr	bute to the	cause of death?
Division of Vital Records,	Hospital or Attanding Physicien: The law requires that the death certif 4 hours after death. 4 hours after death. Funerel Director: After this certificate has been signed by the ettending lief filled in by the funeral director, page 2 should be detached for use a	ted by						1)X(Ye			bly 4 []Unknown
ပို့	law r	Completed						24a. Was an autopsy	/ p	Vere autop	sy findings available pletion of cause of
展	: The							perform 1 Yes 2		eath?	P □ No
Ĭ Š	icien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Death				
ō	Phys rthis ral dii	10	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpaties 28b. Time o	IL SUIDON	4 🗆 Rursing nor	me 5 Reside			
9	th. Afte	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □No		,,		
N S	Attar r dea ector by the	Hca	3 Suicide 6 Could not be determined	286. Place of injury - At n	ome, farm, st	reet, factory, office		28f. Location (Str	eet and Numbe	er or Rural	Route Number,
ā	s afte	Certification:	- C Louincide	building, etc. (Special	(y)			City or Town	, Siale)		
	To the Hospital or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medical (ysician: To the best of my knoniner: On the basis of examination and manner stated.							
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed	(Month, D	ay, Year)
			Variable	- and)	DOC	63129		APRIL 4	1200	6
1	0 (4)			completed cause of death (Item	n 23a) (Type.	Print)					
1			POWLIMI	NADKARNI	, MD	9901 Med	ical Cent	er Drive	, Rock	ville	, MD 20851
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2000	Registrar's Sign	he	B)					

	1	State of Maryland / Department State of Maryland / Department For State Registrar Certifica		lental Hygi	_	13023
Physiciar	1	Decedent's Name (First, Middle, Last) Norma A. Sacker		2. Date of Death Month		- 1 1 U U
/Medica Examine			r, Town, or Location of Death Cambridge		4c. County of Dorch	
Funeral Director		215-24-5975 1 M 2 TDF 83 Yrs. Months	Br 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Nov. 19,	^{Year)} 1922 M	Birthplace (State or Foreign Country) ary Land
show	_ ,	Usuaf Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Dorchester	Cambridge			10d. Inside City Limits 1 ☐ ¥es 2 ☐ No
vith the N	<u>ن</u>	10e. Street and Number 10f. Z	ip Code	10	g. Citizen of What	
iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic event, the Marical Examiner must be nutified at	by Funeral	Apt. 104, 224 Meteor Ave. 11. Marital Status 1 Never Married 2 Married 3 Woodwad 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Spo If Yes, Give Year or Dates:	21613 edent of Hispanic Origin? (Specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)	Black, W	USA merican Indian, hite, etc. hite
i within 72 hou liene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of work	ing 1	6b. Kind of Busine	ss/Industry 1 Home
2 should be filed within and Mental Hygiene is marked other than summatic event, Ira M	lo Be	17. Father's Name (First, Middle, Last) Clarence Nichols Aaron		e (First, Middle, M n Mae Cre		
			ss (Street and Number or Rur St., Cambrid		City or Town, Stat 21613	e, Zip Code)
perrit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is any injury or other tra		20a. Method of Disposition 1 Burial 2 Oremation 3 Removal from State 1 Donation 5 Other (Specify)	other place)		Oc. Location · City Hurlock,	
permit Pages Department of Important: If it any injury or o	1	2/ Signature of Funeral Service Licensee Mid S.	and Address of Facility hore Cremation Hudson Rd., Ca	n Center,	P.O. Bo	ox 1464,
Mary No.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart salture. List only one cause on each line.	ode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Prrysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. An Civonn Civonn Condition of the cond	vorva of Les	u_		6 mes
te be ysicie	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	8	0		
The law requires that the death certificate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 2 State State Unknown Unknow			23d. Date of Month	delivery Day Year
uires that the signed by tid be detacted.	۾	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.			e to the cause of death? Probably 4 Onknown
The lay	Completed			24a. Was ar autopsy perform 1 Tyes 2	prior	
OI VICAL Physician: This certifica	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Other	th <i>(Check only one</i>	nce 6 Other (\$	Specify)
Jing Jing After fune	ation; T	27. Manner of Death Naturaf 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
DIVISIO	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ory, office	28f. Location (Sti City or Town		r Rural Route Number,
	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurre on the basis of examination and/or investigation and manner stated.	ed at the time, date and place, on, in my opinion, death occur	and due to the ca rred at the time, da	use(s) and manne ate and place, and	r as stated. due to the cause(s)
To th within To th	Me	> Mittellan	29c. License number 02638		April 3	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J Fallow MA 302 31. Date filed (Month, Day, Year) APR 9 6 2006 32. Registrar's Signature	collins Hu	Nock.	April 3 Mol 71	1643
Stat Registra		31. Date filed (Month, Day, Year) APR 9 6 2006 32. Regitrar's Signature	W			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryland / Dep	artment of Health and N		ene 2005	13025
ı	48 ×	n	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic		Catherine Virginia Stultz		April	8 200	
	Examin	44	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of D	
		v.	2922 Marston Rd.	New Windsor	1 - 2 - 12		rroll
	Funeral Director		5. Social Security Number 219-58-7090 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sept. 10,	^{Yea} ()924	Birthplace (State or Foreign Country) Mary land
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary!	or	Maryland Carroll	New Windsor			1 ☐ Yes 2 ☐ X No
	the 28a-	Directo	10e. Street and Number	10f. Zip Code	10	g. Citizen of Wha	t Country?
	3a or	O E	2922 Marston Rd.	21776		U.S.A	١.
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		American Indian, Vhite, etc.
2	or Ite	by Funeral	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	Triodin, did.)	Canaiku	
Š	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Itema 23a or 28a-f show ant, Ita Mudical Exacular Invative Incilities and		3 Widowed 4 Divorced Year or Dates:				White
2	n 72 nat	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ring	6b. Kind of Busine	ess/industry
7	withi	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	homemaker		own h	ome
2	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, M		
<u></u>	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Items 23a or 28a-f show other traumatic event, it a Medical Exaction in the rectified.	To E	John C. Kirby	Mary	/ Virgini	a Hatfie	eld .
<u></u>	2 sho and I I mu			ing Address (Street and Number or Run			
2 15	l and 2 lealth om 27 I			Marston Rd.		dsor, MD	
2	Pages 1 nent of H ant: If ite ary or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		0c. Location - City	
altillo	nt. Pe					ennings,	
0	permit. Pages 1 and Depertment of Healimportant: If item 2 eny injury or other ODCS.			2. Name and Address of Facility Hai 10 Church St. Ne	tzler Fu w Windso		
Ť			23a. Part1. Enter the disease, or complications that caused the death. Do not en				Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	1 1 Page 1 1 2	1		Interval Between Onset and Death
	/Medical		resulting in death) a	court accord	m.	4	20cm
	Examiner		Sequentially list conditions b. artory	enter accord	who De	rsione	20cm
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
_	and and Il-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
,0070	cate be executed oblysicien and the burial-transit	dical E					
000	g phy:	edic	0.				
5	n the death certific by the attending p tached for use as t	hysician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of	delivery
2	deat he ath	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
ر ا	of the	Phy	9 Unknown		00. 0:444		
Š	The law requires that the death certificate be executed as bas been signed by the attending physicien and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			e to the cause of death? Probably 4 □Unknown
Š	w requir been si should	etec					
บั C	ding Physician: The lav h. After this certificete has funeral director, page 2	Completed			24a. Was an autopsy performe	ed? prior	e autopsy findings available to completion of cause of h?
<u> </u>		ပိ	25. Was case referred to medical	26 Place of Dogs	1 Yes 2 h (Check only one)		Yes 2□ No
>	yslcia s cert direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatie	Other			Specify)
5	ng Ph ter th		27. Manner of Death 28a. Date of Injury 28b. Time of Month, Day Year Injury Injury		28d. Describe how		
2	endir sath. or: Af he fu	atlc	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Ž	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, lactory, office	28f. Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
2	pital ours a orel C		29a. Certifier 1 Certifying Physician: To the best of my knowledge dea				
	Hos 24 ho Fun etely	edical	29a. Certifier 1	in occurred at the time, date and place, ovestigation, in my opinion, death occur	red at the time, dat	e and place, and	due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (M	onth, Day, Year)
	111		Chim Maddeta	725443	4	1/10/-	relet.
	WJ		30. Name and address of person who completed cause of seath (Item 23a) (Type	, Print)	1. 1	/ .	1 \ \
	ت		John W. Middleton MD 6	DISTUB RE Porte Real	Nest	minste	MUZILY
	Sta Registr		31. Date filled (Month, Day, Year) 32. Registrar's Signature	1			,
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		FILL IT LOUD BUREARS ST.	CARATA 1			

State of Maryland / Department of Health and Mental Hygiene ReginoUUD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EDDIE SADDLER, JR /Medical 4b. City, Town, or Location of Death facility Name (If not institution, give street and number Examiner 8. Date of Birth (Month, Day, Yea March 5, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 XM 2 ☐ F Hours Yrs. 492-32-7027 1932 74 Director Mississippi Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28e-f show or other treumatic event, the Medical Examiner must be notified at 1 TyYes 2 □ No Be Completed by Funeral Director Maryland Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 341 Walker Street or Items 23e 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 GPyes 2 □ No If Yes, Give Year or Dates: 1953-73 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: SpecifyBlack 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Self Employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental h Pages 1 and 2 should be Eddie Saddler Effie Larry ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 Is eny injury or other tree Mary Saddler / wife 341 Walker Street, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/17/06 Garrison Forest VA Cem Owings Mills, Maryland * 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac MINHURS arrythemias /Medical Due to (or as a consequence of): Examiner 1 year heart disease Hypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 ☐ Probably 4 DUnknown Crutellelt Jacob's disease 1 ☐ Yes 2 ☐ No Dicheles mellinis Ventilater dependent 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Kerphatery Jeilhre 24a. Was an autopsy performed? Yes 202 No Division of Vital Hospitel or Attending Physicien: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 PInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4-10-2006 D 36494 DESA/MO 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 South chairles St Baltimore mp 21230 WSH DESAIMO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Physician Margaret April 8. Singer 2006 12:02 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 70 August 18,1935 West Virginia Director 233-50-3171 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r Items 23a or 28e-f shov ther must be notified at 1 ☐ Yes 2X No Maryland Cecil E1kton permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "national injury or other treumation." Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 186 Woods Way 21921 United States Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No 11. Marital Status 1 Never Married 217 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Smith Ingram ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert F. Singer 186 Woods Way Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 1 □ Burial 2 In Cremation 3 □ Removal from State Mayerdale Crematory Newark, Delaware 2006 4 □ Donation 5 □ Other (Specify) 21. Signatur (1) ral Service 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final Staphlococcal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Chronis Obstructure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Apy Tobacco Due to (or as a consequence of) physician a s the burial-1 P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypeclipidemic has autopsy certificate 1 ☐ Yes 2 ☐ No 05/00000 10515 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: ion 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 50 within 24 hours a To the Funerel I Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical Ped: 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 81 Mysician ss of person who completed cause of death (Item 23a) (Type, Print) Elkron West. Ste 312 Cydney T Ted 111 tech M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1 2006

			State of Maryland / Den	partment of Health and Mental Hygiene	
			g.c.	ertificate of Death Reg. No.	JU6 13028
П	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> Edith Louise Smith	2. Date of Death Month Day	3. Time of Death
	/Medic	al	Edith Louise Smith 4a. Facility Name (If not institution, give street and number)		2006 8:25 a ^M
	Examin	er	Millennium Health & Rehab.		ne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 579-40-4995 77 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 5, 192	9. Birthplace (State or Foreign Country) Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	a-f sh	ctor	MD Anne Arundel Edgewat	cer	1 ☐ Yes 2 📉 No
	th with the 23a or 28 ast be not	Funeral Director	10e. Street and Number 144 Washington Road		n of What Country? S • A •
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant. It is Medical Evaria or must be routlifed at once.	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	. Race - American Indian, Black, White, etc. pecify: white
21215-0036	within 72 ho ine. ihan "natur is Medicul	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	of Business/Industry
d 2	filed v Hygie Sther t		10 Call 17. Father's Name (First, Middle, Last)	Feteria worker scho	<u> </u>
<u>ylan</u>	Mental Mental arked atic av	To Be	Charles King	Elsie Seaborn	
Maryland	nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mai Mildred Beall, daughter 311	ling Address (Street and Number or Rural Route Number, City or T Ella Drive, Lothian, MD 2071	
Baltimore,	ges 1 a of Hea of itam		20a. Method of Disposition 1 Removal from State 20b. Place of Disposition cemetery, or	ematory or other place)	tion - City or Town, State
Ħ	artmen artmen ortant: injury	-		Memorial Garden 04-13-06 Wald	orf, MD
Ba	Depar Impo any ir		Duya / Jubach 1	Rausch Funeral Home, P.A., Owi	ngs, MD 20736
	- 5.		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only only cause on each line. Immediate Cause (Final	**************************************	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a	Amhythmici	
	Examiner		Sequentially list conditions, if any, leading to immediate b. P+Neroscience Due to (or as a consequence of):	tic Cardio Vasuular disteo	rse
_	uted d ansit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
30,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):		
68760,	ficate t physics to the b	edicai	d		
P.O. Box	that the death certifical bed by the attending phy detached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)	d. Date of delivery Month Day Year
	Se 75 90	by Pr	Part II. Other significant conditions contributing to death but not resulting in the		contribute to the cause of death?
ord	w require been sign	eted	Diabetes mellitus - Insi	*	
of Vital Records,	The ate h page	Completed	Covonary Artery directe, Abo	Ominal wall Absariores 22 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
XIII		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatie	26. Place of Death (Check only one) ont 3 DOA Other: 4 Nursing Home 5 Residence 6	Other (Specify)
n of	iding Phys th. : After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work? 28d. Describe how injury of	
Division	or Attending after death. Diractor: After In by the funer	licati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No treet factory office 28f. Location (Street and N	Number or Rural Route Number,
Ω	ital or A	Certification;	3 ☐ Suicide 4 ☐ Homicide		
	To the Hospital or Attenwilhin 24 hours after deati To the Funeral Diractor: completely filled in by the	ledicai	(Check only 2 Medicel Exeminer: On the basis of examination and/or in one)	th occurred at the time, date and place, and due to the cause(s) are nvestigation, in my opinion, death occurred at the time, date and place.	ace, and due to the cause(s)
)	To the within To that complete	Z	29b. Signature and title of certifier Cuffer C. Smaa	. D 50653 4-	signed (Month, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type 5851 - Deale Churc	7/411.	0751.
	Sta Registr	te ar	31. Date filed (Month, Day Year) APR 1 1 2005	Sperke	

			1 - State Ragistrar	State of I	Marylan		artment			and Ment		jiene	06	13029
			1. Decedent's Name (First, Middle, L.	ast)							ate of Dea	th	407 1007	3. Time of Death
н	Physici /Medio		Keith		W.		Sutt	on			onth arch	31	2006	8:15 p ^M
	Examir		4a. Facility Name (If not institution, gi	ve street and numb	er)				Location of	of Death			unty of Dea	
			990 Hillendale	Drive			Anna	ipol:	is			Anı	ne Aru	undel
	Funeral					last birthday)	If Under Months	1 Year Days	If Under		ate of Birth)		thplace (State or Foreign ountry)
	Director		218-84-1256	1 ∑ M 2□F	45	Yrs.		Duys	110010	0ct	9,	1960		aryland
	pue A		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town or Lo	cation					-		10d. Inside City Limits
	daryli etho	ច	MD Anne A	rundel		napoli								1 □ Yes 2 No
	28a-1	Director	10e. Street and Number	Lander	Al	Парот	10f. Zip	Code	-		· · · · · · · · · · · · · · · · · · ·	Og Citizon	of What Co	
	with a	5	990 Hillendale D	rive			101. 210	2140	าด				SA	outiny :
	death with the Maryland me 23s or 28s-f ehow fimust be notified at	Funerai	11. Marital Status	12. Was Decede	nt Ever in U.	.S. 13. ¹	Was Deced			ain? (Specify)	es or No-			erican Indian,
	riter of	Fu	1 ☐ Never Married 2 Married	Armed Force	s?	1				gin? (Specify) i, Puerto Rican	, etc.)		Black, Whit	te, etc.
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	is:		1 ☐ Yes 2	2 ∆ No	Specify:			Sp	ec <i>ify:</i> Wh	nite
2-0	d within 72 hours after death with the Marylan jiene. I than "naturel", or iteme 23a or 28a-f ehow The Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gi			16a. Deced	dent's Usua	l Occupa	ation	t of working		16b. Kind	of Business	/Industry
2	within Bne. than	npie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired,)	t of working				
7	Hygien Hygien ther th	် ပ	12			Drive	er					UPS		
<u>n</u>	be filed tal Hygin d other event,	Be	17. Father's Name (First, Middle, Las							r's Name <i>(Fir</i> s			пате)	
Z	ould Men Marke	၉	Thomas C. Sutto							lyn L.				
Maryland 21215-0036	and and le m		19a. Informant's Name/Relationship				_			or or Rural Rou		-		
ď	1 and 16alth 17 m 27		Suzann A. Sutto	n (Wlie)	20h B					ve, Ann	-			
0	H Ite		1XX urial 2 ☐ Cremation 3 (☐Removal from Sta	100	Place of Dispo semetery, cren			1					Town, State
Ë	tmen tant:		4 □ Donation 5 □ Other (Spec		Lak					4-7-200	16	Davids	30nvi]	lle, MD
Baltimore,	permit. Pages 1 and 2 should be filed Deperment of Health and Mental Hyg Important: If Item 27 Is marked othe important: or other traumatic event, any injury or other traumatic event, ance.		21. Signature of Funeral Service Lie	200		22	. Name and Harde	sty	Fune:	ral Hom	ne, P	.A.		
_	40.200			8			12 Ri	.dge]	Ly Ave	enue, A	nnap	olis,	MD 21	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each	sed the death h line.	n. Do not ent	er the mode	of dying	g, such as	cardiac or resp	iratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. DNS	tate	Car	CRV							1.5 40avs
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):								
		-	Sequentially list conditions,	b. Phone to fore	dš a čijiišelji	cours of								
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	adrice oi).								
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
8760,	cate be executed bhysicien and the burial-transit					, .								
687	icate phys s the	Physician/Medical		_ d.										
Box (death certific: e ettending pl ed for use as t	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna	ancy						234	Date of del	iven
ă	etter for u	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pre Other (spe					200.	Month	Day Year
P.O.	at the de by the c	Jysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr	1									
	faw requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions	contributing to deat	h but not rest	ulting in the ur	nderlying ca	use give	n in Part I.	2	3e. Did to	pacco use o	contribute to	the cause of death?
g	o slo						_				1 □ Y	s 2 20	√ 3 □ Pr	robably 4 Unknown
8	w requir	jet								2	4a. Wasa	n 24	4b. Were au	itopsy findings available
æ	e - B	Completed									autops perfort	y ea	prior to death?	completion of cause of
<u>ra</u>	iclan: Th certificate rector, pag	Ö	25. Was case referred to medical			tine	eene .		ne Place		☐ Yes .<	-	1 🗆 Yes	2 No
>	Phyelclan: r this certific ral director,	To B	examiner?	Hospital:	atient 2 🗆	ER/Outpatien	t 3□ DO	Othe	-	of Death (Cha			Other /See	a.h.l
Division of Vital Records,	To the Hoepital or Attending Physician: which 24 hours state death of the Funatal Director: After this certific completely filled in by the funeral director,		27. Manner of Death	28a. Date of I	njury	28b. Time of		Bc. Injury Work		-	-	ow injury oc		cay)
<u>o</u>	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		Day Year)	Injury	М		? ′es 2 🗆 1	No				
Vis	or Attendation of the control of the	iii Ci	3 ☐ Suicide 6 ☐ Could not I	286. Place of	Injury - At ho	ome, farm, str	eet, factory,	office					umber or Ru	ural Route Number,
Ö	s afte	Certification:	Tiomida	building,	etc. (Specify	<i>y</i>)				C	ity or Towi	i, State)		
	the Hoepital hin 24 hours the Funeral the Funeral upletely filled		29a. Certifier 1 Certifying P	hysician: To the be	st of my kno	wledge, death	occurred a	t the tim	e, date and	d place, and du	e to the c	ause(s) and	manner as	stated.
	he Ho n 24 he Fu	edicai	one)	miner: On the basis and manner	s of examinal stated.	tion and/or inv	estigation,	in my op	inion, deat	th occurred at t	the time, d	ate and pla	ce, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral Completely filled it	Σ	29b. Signature and title of certifier		0			License						h. Day, Year)
			Jam We	~ n	W		L	252	830	>	1	tp/1	13,	2006
			30. Name and address of person who	completed cause of	of death (Item	а 23а) (Туре,	Print)	-	0	10.7			,	1
			Jeanine Well	er MI	90	00 BC	sta	ak	14	#300	An	1aps	(15,W	2006 1P 7140/
	Sta		31. Date filed (Month, Day Year) 20	06 72. Regi	strar's Signa	ture de	1			,		-		
	Registr	ar	ALIN 9 0 40	-		1								

			1 - For State Registrar	State of I	Maryland		artmen rtificate				F	Reg. No.	006	130	30
	Physici	an	1. Decedent's Name (First, Middle,	Last)							Date of Dea Month	Dav	Year	3. Time o	
	/Medic		Goldie L. Stepho								April 1	16, 2		11:45	5 P M
	Examin	er	4a. Facility Name (If not institution,		er)				Location o	of Death			County of Death .11egany		
			Memorial Hospi 5. Social Security Number		Age (In yrs. las	t hirthday)		berl 1 Year		24 Hrs.	8. Date of Birtl			place (State	or Foreign
	Funeral Director		214-78-0809	1□M 2 X F	47	Yrs.	Months	Days	Hours	Min.	(Month, Da) 04/06/	y, Year)	Cor	intry)	
			Usual Residence of Decedent		- 7/						04/00/.				
	nylan how		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside C	
	Ba-f.	cto	W. Va. Miner	al	Key	ser									2 □ No
	with th	Dir.	10e. Street and Number				10f. Zip						en of What Cou	intry?	
	s 23	erai	60 South F Stree	12. Was Decede	nt Ever in II S	12		26726		inin? (Snec	cify Yes or No-		A. Race - Amer	ican Indian	
	ter d	Funeral Director	1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?		If Yes, spec	cify Cuba	in, Mexicar	n, Puerto R	lican, etc.)		Black, White		
936	urs a	by	3 ☐ Widowed 4 Divorced	If Yes, Give Year or Date		:	1 🗌 Yes	2 XX 10	Specify:			5	Specify: Whi:	te	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28e-1 show disal Examinar must be notified at	Completed	15. Decedent's (Specify only highest				dent's Usua kind of wo			t of workin	a	16b. Kin	d of Business/l	ndustry	
2	ithin nen	npie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	se retired	1)			_			
2	tygier fy		10 17. Father's Name (First, Middle, L	act)		E	lome M	lake		ar'e Namo	(First, Middle,		m Home		
anc	ntal H ed of	Be	Charles O. Spur								Ann Joi		,amamo,		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic avent, the Medical Examinat must be notified at	ဥ	19a. Informant's Name/Relationshi			19b. Maili	ng Address	(Street					Town, State, Zi	ip Code)	
	nd 2 string at trau		Dianna M. Redman	/ Sister		60 So	uth E	Sti	reet	Kevs	er, W.	Va.	2 6 726		
Baltimore,	s 1 al		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nar	ne of			ate		ation - City or T	own, State	
Ĕ	Page nent c int: #		WXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		110		Garde		4	4/20/	2006	Kevs	ser, W.	Va.	
alti	permit. Pages : Department of H Importent: If Ite any injury or ot		21. Signature of Funeral Service Li	censee	. ,				ss of Facili	ty Smi	th Fun	eral	Home		
_	207 2 2		23a, Part1, Enter the disease, or o	Four	th								la. 2672	26 Approxima	
8760,	death certificate be executed Reading physicien and death cutse as the burial-fransit	ical Examiner	disease or condition resulting in death) Sequentially list conditions, I any, warm of the minimarket cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or	as a conseque	nce of):). 							10 00	248 ———
.O. Box 6	the che	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		n 2 ∏ Fetal d tat time of dea	eath 3[∃Ectopic pr ∃ Other (sp		′			23	3d. Date of deli	,	Year
ď		by Pi	Part II. Other significant condition						en in Part I	1.	23e. Did to	obacco us	e contribute to	the cause of	death?
ğ	- w -	ed	Sepsis Ken	al Faile	ire, K	espi	rati	Dry	Fai	lure,	1 1	res 2□	No 3□Pro	obably 4 🗌	Unknown
of Vital Records,	aw 2 s	Completed	Encephelopa	thy Chr	onic C	1651	ruct	ive			24a. Was		24b. Were aut	topsy findings	available
Ě	The ate h page	EO	Pulmonary J								perfo	rmed? 2 No	death?	2 🗆 No	
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to m dical examiner?					- 101		e of Death	(Check only o	ne)			
¥.	Physician: this certific ral director.	၉	1 ☐ Yes 2 No	Hospital: 1 Sanp		VOutpatie			4 🗆 🔃				Other (Spec	rify)	
N C	ling After une	io	27. Manner of Death 1. ■Natural 5 □ Pending		Day Year)	8b. Time o Injury	M 2	28c. Injun Wor	yat k? Yes 2.∐		8d. Describe I	now injury	occurred		
Division	or At fter o	Certification:	2 Accident investigation 3 Suicide 6 Could not determine 4 Homicide determine	ot be 28e. Place of	Injury - At hom , etc. (Specify)	e, farm, st			.03 2		8f. Location (5 City or Tox		Number or Ru	ral Route Nur	nber.
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C		Physician: To the be xaminer: On the basi and manner	s of examinatio										s)
	To the To the Comp	Σ	29b. Signa ure/and title of certifier	71	\overline{all} .	4	290	c. Licens	e number				signed (Month		
•			Jun ((Knl	LI	10		D 1.	821	6		April	17,	2006	
0	7	ر ا		no completed cause	of death (Item 2		1	,			1	1	113		
U	1		31. Date filed (Month, Day, Year)	mith mo	istrar's Signatu	Set	on.	Dri	ve, (um	per la	nd,	MDo	1500)
	Sta Regist		APR 2 4	2006	Deser A	A A	conte								

		•	For State Registrar	State of	Maryland / De	epartmen Certificat				fental Hy	giene		6	3031
			Decedent's Name (First, Middle,	Last)						2. Date of De	eath			3. Time of Death
	Physici		John C.	Twitty						April	Day 3		Year 106	3:20 A M
7	/Medic Examin		4a. Facility Name (If not institution,	give street and nun	nber)	4b. City,	Town, or	Location	of Death		4c.	County o	f Death	
			Suburban H	lospital				Bethe	esda			M	lontg	gomery
	Funeral Director		5. Social Security Number 123–01–4967	6. Sex 1 AM 2 ☐ F	7. Age (In yrs. last birtho 87 Yr	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Jan。 1	th ay, $Y \theta a r$, 19	19	Cour	lace (State or Foreign try) 7 York
	DC &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	r Location							1	0d. Inside City Limits
	ehor	7			100.00,70	Loodion		(71		71				1 X Yes 2 □ No
	789-f	Director	Maryland Mont	gomery		10f 7ir	Code	Che	evy (Chase	10g Citi	zen of W	hat Cour	try?
	with		8700 Jones M	Hill Road		101. 21	0 0000	208	215		rog. Oit.			States
	ne 23	erai	11. Marital Status		dent Ever in U.S.	13. Was Dece	dent of H			ecify Yes or N	0-			an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23e or 28e-f ehow any highry or other treumatic event, the Madical Exacidant must be notified at ance.	by Funerai	1 Never Married 2 Marri 3 Widowed 4 Divorced	Amed For	2 □ No e	If Yes, spe		Specify		ecify Yes or No Rican, etc.)		Black Specify:	, White, BJ	₋ ack
Maryland 21215-0036	2 hou	ted	15. Decedent			ecedent's Usu			- 4 - 4 4		16b. Ki	nd of Bus	iness/In	dustry
712	7 nin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	college (1		Give kind of wo fe. DO NOT u	ork done d ise retired	during mos i)	st of work	ang				
2	giene giene	E C	Elanomary (5 12)	4		Forei	gn S	ervi	ce Of	ficer		Gov	ernn	ent
ğ	al Hy othe	Be	17. Father's Name (First, Middle, I					18. Moth	er's Nam	e (First, Middle)	
<u>a</u>	uld b Venta	To E	Frank	E. Twitty	7					U ₁	nknow	m		
an	and Parme	0	19a. Informant's Name/Relationsh	iip (Type, Print)	19b. M	lailing Address	s (Street	and Numb	er or Rui	ral Route Numb	ber, City o	r Town, S	State, Zip	Code)
Σ	and 2 salth n 27 l		Jeffrey D. Ma	11ett/Gra				ng Te		e, Gree				
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from :		crematory or	other plac			Date			•	wn, State
Ĕ	Pag ment ant: I ury o		4 □Donation 5 □Other (Sp		Lee	s Crem	ator	у		2006		Clin		
Baltimore,	permit. Departr Imports eny inj		21. Signature of fluneral Service I	icensee	+ 111	22. Name a			•	Stewart				DC 20019
			23a. Part 1. Enter the disease, or	complications that c	aused the death. Do no	enter the mo							Ť	Approximate
			shock, di heart failure. List	only one cause on e	ach line.		·							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		epsis or as a consequence of									2 Weeks
	Examiner													10 D
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to t	yelonephrit oras a sonsequence of	1S								10 Days
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. ————————————————————————————————————	therosclero	sis -								Years
ć	execut an an ial-tr	Exa	resulting in death) Last		or as a consequence of									
8760,	cate be executed physician and s the burial-transit	dicai		d									_	
9	rtifica ng ph as th	Jed	DE FEMALE.										- 1	
Вох	death certific e attending p ed for use as i	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy irth 2 Petat death	3 □Ectopic p	regnancy	,			:	23d. Date Mon		Day Year
E	0 0 0	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death	5 Other (s	pecify)					MOI		Day Tear
<u>Ф</u> .	that the de led by the a	F	9 Unknown					an in Dad		22a Did	tohoooo	oo sontri	buta ta t	ne cause of death?
Division of Vital Records,	tw requires that the s been signed by th ? should be detache		Part II. Other significant condition Dial	etes Mell		ne underlying	cause giv	en in Pan						ably 4 □Unknown
3eco	e law has t je 2 s	Completed	Rena	ıl failure	2					24a. Was	opsv	DI	ere auto	psy findings available mpletion of cause of
a	ician: The la certificate ha rector, page 3			ertension				22 51	/ 5		formed? 2 🔯 No	1	□ Yes	2 □ No
⋚	sicia certi recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗓 No	Hospital:	npatient 2 ☐ ER/Outp	ations 200	Oth Oth	oc.		th <i>(Check</i> on <i>ly</i> ome 5 ☐ Res		e 🗆 Otho	- /C	
ō	Physic ruthis ral di	5 T:	27. Manner of Death	28a. Date	of Injury 28b. Tir		28c. Injur	y at	iursing n	28d. Describe		_		y)
O	ding th: Afte	tior	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	9	th, Day Year) Inj	ury M	Wor 1 □	k? Yes 2.⊑	No					
isi	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place	of Injury - At home, farm	n, street, factor	ry, office			28f. Location	(Street an	d Numbe	or Rura	I Route Number,
ă	after Dire	Certification;	4 Homicide	buildi	ng, etc. (Specify)					City or 10	own, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	(Check only 2 Medical	Examiner: On the ba	best of my knowledge, asis of examination and									
	To the within 2. To the complet	Med	one) 29b. Signature and title of certifier		ner stated.	20	c. Licens	e number			29d. Dat	te signed	(Month	Day, Year)
1	To Toon	-	255. Signature and title of Certifier	. K. T	40.		171	961	10			3.2		_
y yl	n 3		/ www	uba samplated as	on of death (from 32a) or	uno Brint'	ソー	100	- 1			J. /		
A	4		30. Name and address of person Raman R.	Tuli, M.I). 10810 Dan	nestow	n Ro	ad, S	Suite	e 202,	Gaith	nersb	urg,	MD 20878
4	Sta		31. Date filed (Month, Day, Year)	32. F	legistrar's Signature									
	Regist	rar	APR 1 0 200	b poery	La Marie									

DHMH 17 Rev 1/200

150+4170hn 4-3-06

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) Day Year Month **Physician** 9:44 PM MARCH 31 2006 hitley lesda /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (Innot institution, give street and number) Examiner PRINCE GEORGE'S SPRINGDALE 9508 STONEY RIDGE ROAD If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours **Funeral** 1 □ M 25 F PENNSÝLVANIA Yrs. JAN 4 1946 60 Director 578-64-0453 Usual Residence of Decedent 10d. Insida City Limits 10c. City, Town or Location filad within 72 hours aftar death with tha Maryland 10a. Stata 10b. County r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at Y☐ Yas 2 No SPRINGDALE PRINCE GEORGE'S Funeral Director MD 10g. Citizan of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20774 9508 STONEY RIDGE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? 11. Marital Status 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: BLACK 1 ☐ Nevar Married 2 ☑ Married Maryland 21215-0020 1 Yas 2 No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) I Hygiana. College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT COMPUTER ANALYST 12th 18. Mothar's Name (First, Middle, Maiden Sumame) 7 is marked other traumatic event, 17. Fathar's Name (First, Middle, Last) permit. Pagas 1 and 2 should be file Department of Haalth and Mantal Hy Important: if item 27 is marked othwany Injury or other traumatic event RICHARDSON ODELLA **JAMES** DUNMORE 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 508 STONEY RIDGE ROAD SPRINGDALE MARYLAND 20774 TISDALE/HUSBAND JAMES 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20c. Location - City or Town, Stata 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/10/06 LANDOVER, MARYLAND HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signatura of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical Examine Examiner requires that the death cartificate be axecuted physician and s tha burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Last (Ar as a consequence of) Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): signad by the attanding be datached for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 3 Probably 4 Unknown 1 Yes 2 No signad 2 24b. Ware eutopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed Aftar this cartificata has 1□Yas 2□No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completally filled in by the funeral director, it 25. Was casa refarred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pasidence 6 □Othar (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 28d. Describe how injury occurred Data of Injury (Month, Dey Year) 28b. Tima of 27. Manner of Death Certification: 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 6 ☐ Could not be determined 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, data end place, and due to the cause(s) and mannar es steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and titla of certifier K d cause of death (Item 23a) (Type, Print) 363 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registra

APR 0 7

2006

			For	State of Maryla	nd / Depa	artment of I	Health and		-	_	e.
			1 - State Registrar		Ce	rtificate of	Death	1		. No.	10000
	Physicia	an	1. Decedent's Name (First, Middle, Las						ite of Death	Day Y	3. Time of Death
	/Medic	cal	Ellen Ridgeway	Tubiolo		4h Cibi Tour	and another of De	0	4 (4c. County of	6 15,09
	Examin	er	4a. Facility Name (If not institution, give Washington Adven			Takoma	or Location of De Park	eatn			tgomery
-	Funeral		Social Security Number 6. S		s. last birthday)	If Under 1 Year	If Under 24 H	Hrs. 8. Da	te of Birth		
	Director			□M 25kF 75		Months Days	Hours M	May	te of Birth onth, Day, Y 21, 1	930 M	Birthplace (State or Foreign Country) laryland
	2		Usual Residence of Decedent	100	V. T						104 1-14-05-11-1
	arylar how	_	10a. State 10b. County		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ectc	Maryland Montgo:	mery S	ilver S	pring 10f. Zip Code			100	. Çitizen of Wha	
	with	ä	602 Deerfield Av	enue		20910			100	USA	at Country:
	ns 23	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of	Hispanic Origin?	? (Specify Y	es or No-	14. Race -	American Indian,
0	or Item	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔣 No				uerto Rican,	etc.)	Specif Wh	White, etc.
3	rel', c	d by	3 ☐ Widowed 4x ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 218 No	Specify:			Specify	1106
5	within 72 hours after death with the Maryland ene. Then *naturel', or items 23e or 28s-f ehow the Modical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece (Give	dent's Usual Occu kind of work done	pation during most of	working	16	b. Kind of Busin	ess/Industry
4	within then then	d d	Elementary/Secondary (0-12)	College (1-4or 5+) 4		<i>DO NOT</i> us <i>e retire</i> ıman Resc				Retail	
У 3	filed Hygin other	ပို	17. Father's Name (First, Middle, Last)		110	mun nobo		Name (First	, Middle, Ma	iden Sumame)	
<u> </u>	ld be ental ked c	ToB	Wilbur E. Ridgew	ay			Elle	n Jen	sen		
a S	shou and M s mar		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stree	t and Number or	r Rural Rout	e Number, (City or Town, Sta	ate, Zip Code)
Ξ	and 2 salth a n 27 i		Ellen Lucille Ma				pi Aven	ue, S	ilver	Spring,	MD 20910
<u> </u>	S S S S S S S S S S S S S S S S S S S		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ace) Ap	Date	5,	c. Location - Cit	y or Town, State
	Lant Bant		4 Donation 5 Other (Specific	y) Me	-	n Cremator		2006	A1		a, Virginia
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Patturet', or items 23e or 28e-f ehow eny injury or other treumatic event, the Modical Examination use the notified at once.		21. Signature of Funeral Service Licer	Dy in	F1	2. Name and Addr cancis J. O Univer	ess of Facility Collin Sity Dl	s Fun	eral H , Eilv	Home Inc	ng, MD 20901
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the de							Approximate Interval Between
4	hysician		Immediate Cause (Final disease or condition	. ASPIRA	110K		KUM				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse				,		Н	
	LXammer	ē	Sequentially list conditions.	b. CEVEYS Due to (or as a const	1	41cu L	mc is	320	DAN	, ,	
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1A 4 D15	M TY	W810	W				
	execunand and all-tra	Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
9	death certificate be executed e attending physicien and id for use as the burial-transit	cail		d Alli	AL	FIBIL	un	710	\sim		
8	w requires that the death certificate been signed by the attending phys should be detached for use as the	Medi	IE SEMANE								
Š	th ce tendii	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		∃Ectopic pregnand	су			23d. Date of	f delivery Day Year
5	the at	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5[Other (specify)				WONG	Day 16a1
·	hat the deby detac	F	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlving cause o	ven in Part I	2	3e. Did toba	cco use contribu	ite to the cause of death?
cords,	The law requires that the at the been signed by the cage 2 should be detached.		DA APRIST	152 JAD	الت التي	1			1 ☐ Yes	2 DING 31	☐ Probably 4 ☐Unknown
כ	w req	Completed						2	4a. Wasan	24b. We	re autoosy findings available
֝֝֝֝֝֝֝֝֝֝֝֝֝֝ ב	he la e hes age 2	Ĕ						_	autopsy performe	d? dea	
<u> </u>	an: T tificat tor, pa	· o	25. Was case referred to medical				26. Place of I	-		10	Yes 2□ No
<u> </u>	ysick is cer direct	O.B	examiner? 1 Yes 2 No	Hospital: 1 Dispatient 2	☐ ER/Outpatie	nt 3 DOA	har			ce 6 □Other	(Specify)
5	ng Ph ter th	n: T	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	f 28c. Inju	iry at	28d. D	escribe how	injury occurred	
2	endir eath. or: Al	atic	2 Accident investigation	n [Yes 2 □ No				
DIVISION	or Att	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe		reet, factory, office		28f. Lo	cation (Stre	et and Number (State)	or Rural Route Number,
_	To the Hospitel or Attending Physicien: The law within 24 burus after death. To the Funerel Director: Attenthis certificate hes completely filled in by the funeral director, page 2 or	O	29a. Certifier 2 Medical Exam	ysicien: To the best of my k	nowledge, deat	h occurred at the t	ime, date and pla	lace, and du	e to the cau	se(s) and mann	er as stated.
	the H hin 24 the Fu	Medical	one)	niner: On the basis of exami and manner stated.	nation and/or in		se number	occumed at t			Month, Day, Year)
	-		29b. Signature and title of certifier	Amu M		D	5928	34	250	04 04	-106
	10		30. Name and address of person who	completed cause of death (#	em 23a) (Tvos	Print) SHA	HID ST	HAM	IM, I	AP -	,
			WASHW GTOW / 31. Date filed (Month, Day, Year)	DVENTIST 32. Pregistrar's Sig	108h.	TAN	AMO.	appr	1, 1	イワー	20912.
	Sta Registr			2006 September 2006	J. A	nerte					

DHMH 17 Rev 1/2001

			- Far	Please							All Copie Id Mental H			le.	10001
		•	1 - For State Registrar			•		rtificat				Reg. N	21111	6	13034
	Physici	an	1. Decedent's Name								2. Date of I	D	ay on	(ear	3. Time of Death
	/Media	al		et Mills		. h ==1		4h Cin	T	I continue of F	April	7	200 c. County of		2:30 A M
1	Examir	er		f not institution, give ad Manor	Street and num	iber)		-	entor	Location of D	/eati1	4	Caro		
П	Funeral		5. Social Security N	umber 6. S		7. Age (In yrs.		If Under	r 1 Year Days	If Under 24 Hours	Hrs. 8. Date of 8	Birth Dav. Yea	-)	9. Birthp	place (State or Foreign
	Director		215–26–5		□ M 2(XF	91	Yrs.		Duyo		Aug.	19,	1914	Ma	ryland
	land ow		10a. State	10b. County		10c. Ci	ty, Town or Lo							1	0d. Inside City Limits
\bigcirc	a-f sh	ctor	MD	Carolin	е		Dentor	1							1 🛣 Yes 2 🗆 No
R	with the Maryland is or 28a-f show the rolling at	Dire	10e. Street and Nur	mber				10f. Zip	Code			10g. C	itizen of Wh	nat Cour	ntry?
2	death v	rai		onial Dri		dont Ever in II	16 113		21629		2 (Consider Voc or I	la la	14. Race	Americ	ean Indian
036	or Its	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☒ Widowed	ied 2 Married	12. Was Deced Armed For 1 □ Yes If Yes, Give Year or Da	ces? 2 ⊠ No ∍		was Dece If Yes, spe		spanic Ongin n, Mexican, P Specify:	? (Specify Yes or I Juerto Rican, etc.)	¥0-		White,	
2-0	72 hou	sted	(Spec	15. Decedent's Ed		-	16a. Dece	dent's Usu	al Occupa	ition luring most of	f workina	16b.	Kind of Bus	iness/Ind	dustry
21215-0036	within ne. han "	Completed	Elementary/Seco		College (1-	4or 5+)	life.	DO NOT u	se retired,	ls Cler	-		Hosp	ital	
	filed y Hygie othar I	eu	17. Father's Name	(First, Middle, Last)							Name (First, Midd	le, Maide			
lan	lid ba fental rkad c	ToB	Roy B	enjamin M	ills, S	r.				Beul.	lah Hazel	Bro	oks		
Maryland	2 should be filed within 72 hours and Mental Hygiene. Is marked other then "neturel", reumatic event, the Medical Exe		19a. Informant's Na	ame/Relationship (Type, Print)			-			or Rural Route Nun	-			Code)
6, ≥	1 and Health em 27 ther tr		Paul O. 20a. Method of Dis		Son	20b F					Cambridg		D 2161 Location - C		own State
Baltimore,	permit. Pagas 1 and 2 Department of Health s Important: If item 27 Is any injury or other tra <u>once</u> .		1 ☐ Burial 2	Cremation 3 🗆		late	Place of Disponentery, createry, createry							•	, Jiaio
Ħ	nit. Partme ortan injuri			5 Other (Specify Ineral Service Licen	-	[00]	rcheste			s of Facility	/10/2006 Thomas F		mbride		D A
Ä	Depar Impo		Bn	L k. Bun	>		70	00 Lo	cust	St. Ca	mbridge,			1107	L • 11 •
			23a. Part1. Enter t shock, or hea	he disease, or comp rt failure. List only	plications that ca one cause on ea	used the deat ach line.	th. Do not ent	ter the mod	de of dying	, such as ca	rdiac or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final on	a. end			Dei	ner	itra					Criset and Death
	Examiner			- (Due to (d	or as a consec	quence of):								
	D ==	ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate orlying	Due to (c	or as a consec	quence of):								
	e be axecuted /sician and e burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	5	c	or as a consec	mence of).							-	
'60,	sician and burial-tran	Te l		·	d		, , , , , , , , , , , , , , , , , , , ,								
687	tificate ng phys as the	ledic													
Вох	death certificate e attending phys d for use as the	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12			rth 2 Feta	aldeath 3	⊒Ectopic p					23d. Date Mont		ery Day Year
	the a	ysici	1 ☐ Yes 2 1 9 ☐ Unknown	20 No	4□Pregna 9□ Unkno	ant at time of o wn	death 5□	Other (s)	oecify)						
, P.O.	raquires that the de ean signed by the a nould be detachad t	by Ph	Part II. Other signif	ficent conditions c	ontributing to de	ath but not res	sulting in the u	nderlying	cause give	n in Part I.	23e. Di	tobacco	use contrib	oute to th	ne cause of death?
rds	w raquires bean sign should be										10	Yes :	2 2 4No 3	☐ Prob	ably 4 Unknown
ecc	S S	Completed									24a. Wi	opsv	pri	or to cor	psy findings available mpletion of cause of
al B	ate pag										1 ☐ Yes			ath?] Yes	2□ No
Z.		o Be	25. Was case refer examiner? 1 ☐ Yes 2 🔀		Hospital:	patient 2	TED/Outpotion	nt 3 🗀 D0	Othe	r-	Death (Check on) ng Home 5 ☐ Re		6 Other	/Specifi	Assisted
) of	g Phye ler this neral di	n: To	27. Manner of Deat	h	28a, Date o		28b. Time o		28c. Injury Work		28d. Describ		- / 5	· · · · · · ·	Cirring
sior	Attending Predath. ector: After iby the funera	catio	1 Natural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not be	1		,	М		res 2□No					
Division of Vital Records,	after d Direct in by	Certification:	3 🗍 Suicide 4 🗍 Homicide	determined	28e. Place	of Injury - At h ig, etc. (Speci		reet, factor	y, office		28f. Location City or 1	(Street a own, Sta	ind Number te)	or Rura	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	127Certifying Ph		sis of examina					place, and due to the control occurred at the time				
	To the Within To the	Me	29b. Signature and	title of certifier					c. License			29d. D	ate signed	(Month,	Day, Year)
							-MD	7	000	532:	55	4	17/0	26	
				ress of person who	4.	1 1 01	-1-			Q	Hon M	73	216	<<	
	Sta	ete	31. Date filed (Mor	APR'1	0 200 PE Re	gis ar's Sign	ature	in 1	ire	1105	LOV IN	J	₩ ((¢	2	
	Regist			APK I	ע צטטט	Blown	, K	Ans	S.						

06-0239	7
Thaver.	Gene

ayer, Gene		State	e of Maryland				elible ink nd Mental i	Hygiene	000	. 1000
		1- For State Registrar	•		rtificate of				eg. No. 2006) 1303
Physicia		Decedent's Name (First, Middle, La						Date of Dea Month		3. Time of Death
edical Exami ·	ner	Gene 4a. Facility Name (if not institution, g	Kenton Tha	,		th City Town o	al acation of Day	Month April 7, 20		22:31
		2000 Liberty Grove Road		,	1	Rising Sun	r Location of Dea	ain	4c. County of Dea Cecil	tn
Funeral		Social Security Number 6. 3	Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Ye	ar If Under 24H	rs. 8. Date of 8i	rth (MM/DD/YYYY) 9. 8	irthplace (State or Fore
Director		212-78-4924	X M 2 F	43	Yrs	Months Da	ys Hours M	Aug.	1, 1962 c	ountry) Maryland
		Usual Residence of Decedent					1			
w an		10a. State 10b. County		10c. City,	Town or Locati	on				10d. Inside City Limit
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	Maryland Ceci	il		Col	ora		= = 7	0.000	
e Mar or 28s	Director	1028 Colora Road	3			10f. Zip Code	21017	1	0g Citizen of What Co	
with th		11. Marital Status	12. Was Deceden	t Ever in U.	S. 13 Wa		21917	Specify Yes or No	U.S	• A • rican Indian, 8lack,
leath v	Funeral	1 Never Married 2 X Marrie	Armed Forces				n, Mexican, Puer		White, etc.	ricari ilidiari, diack,
after d	by Fi	3 Widowed 4 Divorce	ed If Yes, Give Year or Dates;	- INU	1	Yes 2X N	o specify:		Specify:	White
hours natur	ed b	15. Decedent's Education (Specify	only highest grade co		16a. Deceden during	t's Usual Occupa	ation (Give kind o	of work done	16b. Kind of Business	•
36 in 72 l han "i	plet	Elementary/Secondary (0-12)	College (1-4 or	5+)	most of v	-	NOT use retired)		Stewart &	
d with giene	Completed	Ten Years 17. Father's Name (First, Middle, Las	at)		1	Pipe Lay		me (First Middle I	Perryville Maiden Surname)	e, Maryland
215 oe files tal Hy ked o	Be		F. Thave	_				etty Jea		
21; ould b d Men s mar fic eve	To I	19a. Informant's Name/Relationship (19b. Mailing	Address (Stre			nber, City or Town, Stat	e, Zip Code)
MD d 2 sh llth an n 27 i		Sharon M. Thaye	r (wife)					lora, Ma	ryland 219	917
ore, sslan of Hea If iter		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from S		Place of Disposi crematory or oth	tion (Name of ce er place)	emetery,	Date	20c. Location - City o	r Town, State
Page ment tant:		4 Donation 5 Other Specif	fy:	We	st Nottir	ngham Ceme	etery 0	4/12/06	Colora, N	Maryland
Balt ermit Depart mpor njury		21. Signature of Funeral Service Lice	ensee	1.	1	ame and Addres		& Son F	uneral Home	D 7
Physician		23a. Part I. Enter the disease, or com	CLUEVAN	the death	Po not enter th	erryvill	e, Mary	land 21	903-0766	Approximate Interva
/Medical		failure. List only one cause on e	each line.		DO HOT OTHER II	io mode or dying	, sacri do carallac	or respiratory and	est, shock, of fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injurie: Due to (or as a cons		f):					Death
-1		Sequentially list conditions,	о.							
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence o	f):					
_ =	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of	f):					
be executed ician and urial - transit	a E		d.							
O, be execut sician and surial - tra	edical	UNPENDED	AMENDED							
Box 68760 death certificate be the attending physical for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregr		al death 3	Ectopic preg	nancy	23d. Date of deliver Month	y Day Y ear
x 68 th cert tendir	icia	past 12 months?	4 Pregnant a	t time of de	oth _	ner (Specify)		riaricy	WORKI	Day feat
Bo ne dear the at	hys	1 Yes 2 No 9 Unknow	9 OHKHOWH							
ires that the destribute is signed by the i	by F	Part II. Other significant conditions	contributing to dea	th but not re	esulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use contribute to s 2 ✓ No 3 Pro	
fs, F quires en sig	ted									bably 4 Unknown
COFC law re has be 2 shor	Completed							24a. Was autop	sy prior to	utopsy findings available completion of cause of
Rec The ficate page	Con							1 Yes	med? death? 2 No 1 ✓ Y	es 2 No
Vital Records, P.O hysician: The law requires that this certificate has been signed by I director, page 2 should be detact	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpati		ED/0.1/		e of Death (Chec			
of V ng Phys After thi	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatient 28b. Time of Ir		Other Nurs		Residence 6 Othe	r: Scene
nding th.	ion	1 Natural 5 Pending	Apr 7, 2006	Year)	0:00		Yes 2 VNo		auto collision	
Division Ial or Attendii rs after death. al Director: A	ficat	2 Accident Investiga 3 Suicide 6 Could no	28e Place of Ir	njury - At ho	me, farm, stree	t, factory, office t	ouilding, etc.	28f. Location (S	Street and Number or Ri	ural Route Number City
Divital or urs after in Illed in	erti	Suicide 6 Could no determine		ajor Road	d / Highway			or Town, S		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification:	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine							e(s) and manner as sta and place, and due to the	
To with	Med	29b. Signature and title of certifier	and manner stated.			29c Licens			29d. Date signed (Mo	
	_	World - A	(16.00			0.0			April 8, 2006	, = =, , , , , , , ,
		30. Name and address of person who	completed cause of	death (Item	23a)					
6			ssistant Medical			enn Street, B	altimore, MD	21201		
	_		1							

State Registrar

APR 1, 0 2006 Sure of Special Section 132. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last)

	0	Ω	1)	6
1	J	U	U	U

Physiciar /Medica Examine
Firmer

Director

within 72 hours after death with the Maryland ed other than "natural", or Itama 23a or 28a-f ahow avant, the Moulcal Examinar count by nutified at permit. Pages 1 end 2 should be filed within: Oppartment of Heelth and Mental Hygiens Important: If item 27 Is marked other than "r. any njury or other traumatic avant, Ita Manana.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

> signed by the attending physicien and d be deteched for use as the burial-transit peen has certificete this completely filled in by the funeral : After

The law requires that the death certificate be executed

To the Hospitel or Attending Physician:

nip

Diractor

within 24 hours a To the Funeral I

Division of Vital Records, P.O. Box 68760,

2. Date of Death Month 3. Time of Death Year CHARLES WILLIAM TRAVERS 8:30 A M APRIL 7. 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARLES WALDORF 12163 ELL LANE, #34 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Ye 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ^{Year} 1918 1**∑**M 2□F Yrs. MARYLAND 88 216-12-2749 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director WALDORF CHARLES MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20602 #34 12163 ELL LANE, Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: BLACK þ lf Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FARMING FARMER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BERTHA FENWICK TRAVERS GEORGE TRAVERS ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 AMBER LEAF PLACE, #24, WALDORF, MD 20602 19a. Informant's Name/Relationship (Type, Print) SHIRLEY MCKAY/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JOSEPH CHURCH CEM 4/12/2006 POMFRET, MARYLAND 21. Signature of Funeral Sergice Libersee with Que ROAD, LYDIA C. THORNTON JOHNSON 'INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unces metastint. Marth Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9□ Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 No 1 Yes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier Med 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of textie 7106 D0040479 30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

Registrar

State

ROBERT DAVISON,

31. Date filed (Month, Day, Year)

M.D.

APR 1 0 2006

32. Registar's Signature

12070 OLD LINE CENTER, WALDORF, MD

DHMH 17 Rev 1/2001

21215-0036

15th .9

90

8

THURDASI

Theodoridis,

		-	For State Registrar	e of Maryland / Depa <i>Cer</i>	tificate of Death	Reg	ZHUD	3036
7 %	张 ·李		Decedent's Name (First, Middle, Last)			2. Date of Death Month	9 2006	3. Time of Death
	Physicia /Medic	al		D. Thomas				10:40 P M
,	Examin		4a. Facility Name (If not institution, give street an 7995 Aladdin Drive	nd number)	4b. City, Town, or Location of Deat Laurel	1	4c. County of Death Howard	
	Funeral Director		5. Social Security Number 6. Sex 120 M 2	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Apr 9, 1	930 Ken	ace (State or Foreign ry) LUCKY
and	*		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10	d. Inside City Limits
Maryl	i-f sho	tor	MD Howard	Laurel				1 ☐ Yes 2 X No
the	or 28a g noti	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?
th W	23a (<u>a</u>	7995 Aladdin Drive		20723		United Sta	
.0036 hours after death with the Maryland	and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner mast be notified at	y Funeral	1 Never Married 2 Married	ed Forces? Yes 2 No	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer I ☐ Yes 🌠 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - America Black, White, of Specify:	etc.
DO:	tural.	ed by	3 ☐ Widowed 4 ☐ Divorced Yea 15. Decedent's Education	r or Dates:1948-52	lent's Usual Occupation	16	Whi-	
Maryland 21215-0036 d 2 should be filed within 72 hours af	ne. han "na te Medic	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College College	eted) (Give	kind of work done during most of wo DO NOT use retired)		epartment (of Defence
Eled 2	Hygie sther	o Co	17. Father's Name (First, Middle, Last)	71 11191		me (First, Middle, Ma		or beraise
ld be	rked c	To Be	Henry Ryan Thomas			ne Ellen A		
Mary of 2 shot	Department of Health and Menta Important: If item 27 is marked any injury or other traumatic stance.		19a. Informant's Name/Relationship (Type, Print Sandra L. Thomas/Wife		ng Address (Street and Number or R Aladdin Drive La			Code)
ore,	of Heal		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal	from State	natory or other place)		oc. Location - City or To	
Baltimore,	artment ortant: injury		* 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		s Cemetery 4-18 Name and Address of FacilityHar		arksville, zke's Fami	
ñ	Depa Impo any ir		Sur Collis t	refle 4	112 Old Columbia	Pike Elli	cott City,	MD 21043
	nysician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	e on each line.	er the mode of dying, such as cardia			Approximate Interval Between Onset and Death
	xaminer		Sequentially list conditions b.	ue to (or as a consequence of):	skin-			
nted	dansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of):				
8760,	physician and s the burial-transit			ue to (or as a consequence of):				
687 ifficate	g phys	edical	d					
Box	ed by the attending p detached for use as	by Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
0	ed by detach	y Phy	Part II. Other significant conditions contribution	ng to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the	-
P.O.	~ ~			Anemia				e cause of death?
ords, P.O.	en signed	ted b	ASCITES	13 11 11 11 19		1 ☐ Yes	2 No 3 Prob	e cause of death? ably 4 DUnknown
Records, P.O.	ite has been signe	completed b	ASCITES	n nrmsq		1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. Were auto prior to condeath?	ably 4 Unknown psy findings available npletion of cause of
	rificate has been signe	Completed	25. Was case referred to medical	n nr///s		24a. Was an autopsy perform	ed? 24b. Were auto prior to condeath?	ably 4 Unknown psy findings available npletion of cause of
of Vital Records, P.O.	his certificate has been signe al director, page 2 should be	To Be Completed	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital	l: 1	nt 3 DOA Other: 4 Nursing	24a. Was an autopsy perform 1 ☐ Yes 2 hath (Check only one Home 5 ∰ Residen	24b. Were autoprior to condeath? No 1 Yes 1 Other (Specific	ably 4 □Unknown psy findings available hpletion of cause of 2√√2 No
on of Vital Records, P.O.	h. After this certificate has been signe funeral director, page 2 should be a	To Be Completed	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital 27. Manner of Death 28a. 1 ☐ Natural 5 ☐ Pending		nt 3 DOA Other: 4 Nursing	24a. Was an autopsy perform 1 Yes 2	24b. Were autoprior to condeath? No 1 Yes 1 Other (Specific	ably 4 □Unknown psy findings available hpletion of cause of 2√√2 No
Division of Vital	of Attendance of the confidence of the confidenc	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No Hospital 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	l: 1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury 28b. Time of	ont 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autopsy perform 1 ☐ Yes 2 ☐ ath (Check only one) Home 5 ☑ Resider 28d. Describe how	24b. Were autoprior to coldeath? Tho 1 Yes Compared Comp	ably 4 Unknown psy findings available inpletion of cause of 22 No
Division of Vital	4 hours after death. Funeral Director: After this certified by filled in by the funeral director.	Certification: To Be Completed	25. Was case referred to medical examiner? 1	i: 1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury (Month, Day Year) Place of Injury - At home, farm, st building, etc. (Specify) To the best of my knowledge, deal	ont 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autopsy perform 1	24b. Were auto prior to condeath? The prior to condea	ably 4 Unknown psy findings available inpletion of cause of 22 No //
Division of Vital	4 hours after death. Funeral Director: After this certified by filled in by the funeral director.	To Be Completed	25. Was case referred to medical examiner? 1	I: 1 Inpatient 2 ER/Outpatie Date of Injury (Month, Day Year) Place of Injury - At home, farm, st building, etc. (Specify) To the best of my knowledge, deat in the basis of examination and/or in	of 3 DOA Other: 4 Nursing 1 Nursing 28c. Injury at Work? 1 Yes 2 No 1 Yes 2 No 1 No occurred at the time, date and place	24a. Was an autopsy perform 1 Yes 2 (ath (Check only one) Home 5 ▼ Residen 28d. Describe how 28f. Location (Stre City or Town, we, and due to the causered at the time, dar	24b. Were auto prior to condeath? The prior to condea	ably 4 Unknown psy findings available inpletion of cause of 22 No // // // // // // // // //
Division of Vital	iffer death. Director: After this certification by the funeral director.	edical Certification: To Be Completed	25. Was case referred to medical examiner? 1	I: 1 Inpatient 2 ER/Outpatie Date of Injury (Month, Day Year) Place of Injury - At home, farm, st building, etc. (Specify) To the best of my knowledge, deat in the basis of examination and/or in	ont 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No reet, factory, office h occurred at the time, date and place twestigation, in my opinion, death occurred.	24a. Was an autopsy perform 1 Yes 2 leath (Check only one) Home 5 N Resider 28d. Describe how 28f. Location (Street City or Town, continue) 29	24b. Were autoprior to coldeath? The first prior to coldeath? Th	ably 4 Unknown psy findings available in the properties of cause
Division of Vital	4 hours after death. Funeral Director: After this certified by filled in by the funeral director.	edical Certification: To Be Completed	25. Was case referred to medical examiner? 1	It Inpatient 2 ER/Outpatie Date of Injury (Month, Day Year) Place of Injury - At home, farm, st building, etc. (Specify) To the best of my knowledge, deal in the basis of examination and/or indicate the state of	ont 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No reet, factory, office h occurred at the time, date and place ovestigation, in my opinion, death occurred at the time of the convention of the con	24a. Was an autopsy perform 1 Yes 2 leath (Check only one Home 5 Residen 28d. Describe how 28f. Location (Street, City or Town, 29 at the time, data 29	24b. Were autoprior to condeath? No 1 Yes Oce 6 Other (Specification of the condeath) Vinjury occurred State) Use(s) and manner as see and place, and due to the condeath of the condeath	ably 4 Unknown psy findings available in pletion of cause of in the cause of

		1 - For State Registrar	State of Maryland /	Department <i>Certificate</i>			giene 06	13039
Physic		1. Decedent's Name (First, Middle, Last) Mary V. Tongue				2. Date of Dea Month April 4	Day Year	3. Time of Death 11:10 A M
/Med Exami		4a. Facility Name (If not institution, give so Anne Arundel Medic		4b. City, T	own, or Location of Death Annapolis		4c. County of Death Anne Arun	1
Funera Director		212-36-6236	M 2DF 7. Age (In yrs. last b	Yrs. If Under 1 Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birt. (Month, Day Feb 3,	h 9. Birth y Year) 9. Birth 1931 Mary	nplace (State or Foreign Intry) Land
te Maryland Ba-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD Anne Anne Anne Anne Anne Anne Anne Anne		wn or Location Annapol				10d. Inside City Limits 10 Yes 2 □ No
ath with the 23a or 2	Funeral Director	1802 E. Copeland S		10f. Zip (2140)1		10g. Citizen of What Cor United Stat	es
ours after dealer, or Iteme	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, speci	ent of Hispanic Origin? (Str fy Cuban Mexican, Puerto D No Specity:	pecify Yes or No- o Rican, etc.)	- 14. Race - Amer Black, White Specify: Black	
od within 72 hours aff gjene. er than "naturel", or	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	College (1-4or 5+)	a. Decedent's Usual (Give kind of work life. DO NOT use Ome Maker	k done during most of work e retired)	king	16b. Kind of Business/I Domestic	ndustry
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinational Discretion To Re Commission by Funeral Discretion		17. Father's Name (First, Middle, Last) Lawrence Thompson			Maude 3	Johnson	Maiden Sumame)	
and 2 sho salth and I n 27 Is me		19a. Informant's Name/Relationship (Tyr. Dorothy M. Tongue/	Daughter 6	11 Tripp	(Street and Number or Ru Creek Court	Annapol	is, MD 2140	1
oermit. Pages 1 ac Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State Chews	of Disposition (Namery, crematory or other UMC Cemo	etery	Apr 8 2006	Owensville,	
permit. Depart Import		21. Sonatyre / Funeral Service Incense	-2/	1922 I	r S Metropol Forest Drive	Annapo	olis, MD	
Physiciar /Medica		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause of each line.	11	1	See & yet		Approximate Interval Between Onset and Death
ite be executed by yesician and multiple burial-transit and		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):	embilient	hernie	à	
death certifine attending I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pre			23d. Date of deli Month	ivery Day Year
law requires that the as been signed by th	ρ	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying ca	use given in Part I.		obacco use contribute to Yes 2 □ No 3 □ Pr	\vee
The The page	Completed					24a. Was autor perfo 1 🗆 Yes	psy prior to or death?	topsy findings available completion of cause of 2 No
Physician: The this certificate rat director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	0.000	Other	th (Check only o	one) dence 6 □Other (Spe	
Phy Phy rat d	1	1 ☐ Yes 2 No 27. Manner of Death 1 Avatural 5 ☐ Pending 2 ☐ Accident investigation	- / \	Outpatient 3☐ DO Time of Injury M	Bc. Injury at Work? 1 Yes 2 No		how injury occurred	элуу
= 2 ft c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory	, office	28f. Location (: City or Tou	Street and Number or Ru wn, State)	ıral Route Number,
the Hospital hin 24 hours a the Funerel i	edical	29a. Certifier (Check only one) Check only	ician: To the best of my knowled her: On the basis of examination and manner stated.	ge, death occurred a and/or investigation,	at the time, date and place in my opinion, death occu	, and due to the rred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within 2 To the complete	M	29b. Signature and title of certifiet	mpleted cause of death (Item 23a Registrar's Signature	29c	D 2 486 4		29d. Date signed (Month) 4 -04-20	h, Dey, Year)
		30. Name and address of person who co Robert Peter	mpleted cause of death (Item 23a	(Type, Print) AMC	Annegali	s Mel	21461	
S Regis	tate strar	31. Date filed (Month Ray, Year) 200	6 Registrar's Signature	book	0			

			For State Registrar	State of Ma	ryland /		artment of tificate of				giene	6	304	. ()
2 5			1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Vaar	3. Time of	Death
	Physici		Elizabeth	Beal	1	Vai	n Meter	2		April		006	4:15	M q
	/Medic Examin		4a. Fecility Name (If not institution, give				4b. City, Town,		of Death			ty of Death		
	LAGITIII	iei	Solomons Nursi	na Cente	r		Sol	Lomons	3			alve	rt.	
	Funeral	-	5. Social Security Number 6. Se	x 7. Age	(In yrs. last b	irthday)	If Under 1 Yea	r If Under	24 Hrs.	8. Date of Birth	1	9. Birth	place (State o	r Foreign
ш	Director		219-20-8601	□M 2 X F	94	Yrs.	Months Day:	s Hours	Min.	(Month, Day Feb 4	, 1912	Mary	land	
	D D		Usual Residence of Decedent											
	how		10a. State 10b. County		10c. City, To	wn or Lo							IOd. Inside Cit	
	e Ma	Director	MD Calve	rt			SOL	omons					1 🗌 Yes	2 NO
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ire	10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Cou	ntry?	
	1h wi		13325 Dowell Road				206	88			US	A		
	dea	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of f Yes, specify Cu	Hispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	14. R	ace - Ameri		
9	or It	F	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 XN If Yes, Give	0		1 ☐ Yes 2 🗓 N			,,	Spec	itu		
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow ta Medical Exercitar mast be notified at	d by	3 Widowed 4 Divorced	Year or Dates:								wh:	ite	
5	72 h 'natu	Completed	15. Decedent's Edi (Specify only highest grad	ucation de <i>completed)</i>	16	(Giva	dent's Usual Occ kind of work don	e durina mos	t of workir	ng	16b. Kind of	Business/In	dustry	
7	ithin	idu	Elementary/Secondary (0-12)	College (1-4or 5-	+)		DO NOT use retii	19 <i>d)</i>						
7	filed w Hygier other th	S	11			C.	lerk	40 14 15		15: 14:11	city		nnent	
ם		Be	17. Father's Name (First, Middle, Last)							(First, Middle,		_		
<u> </u>	2 should be and Mental ie marked o	၉	Lawrence Willia						lie	Eiler		ck ———		
Maryland	and and ie m		19a. Informant's Name/Relationship (T	ype, Print)	19	9b. Mailir	ng Address (Stree	et and Numbe	ar or Rura	l Route Numbe	r, City or Tow	n, State, Zij	Code)	
	and 2 ealth n 27 i		Karen Penn, gr	eat-niec			. Box	195,			206			
ore	of Herritan		20a. Method of Disposition 1 Darial 2 XCremation 3 D	Removal from State	20b. Place cemet	of Dispo e <i>ry</i> , crer	sition (Name of natory or other p	(ace)	D	ate	20c. Location	n - City or T	own, State	
Ĕ	Pages nent of snt: If its sry or o		4 □ Donation 5 □ Other (Specify		Metro	pol:	itan Cre	matory	04-	08–06	Alexa	ndria	, VA	
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 ie marke any injury or other traumatic QDCB.		21. Signature of Funeral Service Licens	see		22	. Name and Add	ress of Facili	ty					
m	Depa Depa Impo any ir		William RC	w		I	Rausch F	uneral	Hom	e, P.A.	, Owin	gs, M	D 207	36
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do					-			Approximate Interval Bet	a ween
	Pnysician		Immediate Cause (Final				End luxo						Onset and I	Death
1.8	/Medical		disease or condition resulting in death)	a Cnrc			Failure					-	O IIIOITE	115
	Examiner			000 10 (0. 20 2		0 0.,.								
念珠。		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence	e of):								
	uted Insit	듣	cause. Enter Underlying Cause (Disease or injury									1		
	al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence	e of):								
760	ate be executed thysicien and the burial-transit	cai	(_										
687	phy:	edic		0.										
	certifi Iding	/W	IF FEMALE:	23c. If yes, outcome of	of pregnancy						23d [ate of deliv	erv	
Вох	atter for L	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth : 4 ☐ Pregnant at			Ectopic pregnar Other (specify)					Month	-	rear
P. O.	he d the	ysic	1 ∐ Yes 2 MaNo 9 ☐ Unknown	9 Unknown		-	3 011.0. (0,000.))							
	Attending Physicien: The law requires that the death certificate be executed refath. refath. ector: After this certificate has been signed by the attending physicien and by the funeral director; page 2 should be detached for use as the burial-transit	F.	Part II. Other significant conditions co	ontributing to death bu	t not resulting	j in the u	nderlying cause g	given in Part I		23e. Did to	bacco use co	ntribute to t	he cause of d	eath?
Records,	signed d be del	d b	Vascular Dise	-			, ,			1 🗆 Y	′es 2 □ No	3 🗀 Pro	bably 4 🔀	Jnknown
Ö	w require been sign	Completed												= 21
ec	e law has t	npi								24a. Was autop		prior to co death?	opsy findings a empletion of c	ause of
=	r: The	S								1 Yes	2 X No		2 🗆 No	
Division of Vital	ysicien: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?	I I A-I					-	(Check only o				
É	Physi this c al dire	P	1 Tes 2 MINO		nt 2 🗆 ERVO					ne 5 🗆 Resid			fy)	
_	ding P h. After t funera	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b	. Time o Injury	N.		1	28d. Describe h	low injury occ	urred		
<u> </u>	endi eath. or: A	Certification:	2 Accident investigation				M 1	Yes 2						
Ξ	l or Atten after deat Director:	ŧ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, . <i>(Specify)</i>	farm, str	eet, factory, offic	е	2	28f. Location (S City or Tow		n <i>ber</i> o <i>r Rur</i>	a <i>l Route Nu</i> m	ber,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		37											
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Exam	ysician: To the best on the basis of	f my knowled examination a	ge, deat and/or in	h occurred at the vestigation, in my	time, date ar opinion, dea	nd place, a ath occurre	and due to the o ad at the time, o	cause(s) and i date and place	manner as s a, and due t	stated. to the cause(s	.)
	To the h within 24 To the f complete	led	one)	and manner sta	ted.						101 5		0	
	To To	2	29b. Signature and title of certifier					nse number			29d. Date sign			
			A 10 10	\sim			D-4	8314			April	J, ZU	000	
	0		30. Name and address of person who o								_		00.555	
	4		Paul Pomilla, N			tal :	Rd., Ste	· 310,	, Pri	nce Fre	ederick	, MD	20678	
		ate	31. Date filed (Month, Day, Year)	32. Registra	s Signature	Lo	A W							
	Regist	rar	MEIN U	7 2005	CEUS	J.	ALCONOMICAL .							

4 M
Box 68760,
P.O.
Records,
Vital
ivision of

		Please Type or Print in Black Indelible Ink. Ensure Al		_	
	1	State of Maryland / Department of Health and M		giene Reg. No. 2006	3041
Physicia	n	1. Decedent's Name (First, Middle, Last) Antonio Laray Williams	2. Date of Dea Month	ath Day Year	3. Time of Death 12.° 26 pm
/Medica Examine Funeral Director	er	Aa. Facility Name (If not institution, give street and number) Doctors Community 5. Social Security Number 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 3. Age (In yrs. last birthday) 4. City, Town, or Location of Death Lanham If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Date 2 / 6 /	4c. County of Dea Prince Prince 9. Bin (V) Year) 9. Bin C 1 958 Nor	
ō		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
death with the Maryland ms 23a or 28a-f show fmust be notified at	Funeral Director	Md Prince George Landover 10e. Street and Number 10f. Zip Code 20785		10g. Citizen of What C	
or Ite	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 Nol 979- If Yes, Sive 1982 1 Yes, Sive 1982 1 Yes, Sive 1982 1 Yes 2 No Specify:	pecify Yes or No Rican, etc.)	Specify:	
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)		16b. Kind of Business	s/Industry
a filed w it Hygier other th	Be Cor	12th Lead Parking Offic 17. Father's Name (First, Middle, Last) 18. Mother's Name		D.C. Gove	ernment
should b nd Ments marked	To	Gurvis Williams Sr Madeli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus	ne Jo		Zip Code)
permit. Pages 1 and 2 should be filed within 72 he permit. Pages 1 and 2 should be filed within 72 he proportenent of Health and Mental Hygiene. Important: If Item 27 le marked other than "naturany injury or other traumatic event, the Medical pince.	- 1	202. Metrod of Disposition 2 Democratic Cemetery, crematory or other place)	Date	20c. Location - City o	r Town, State
permit. Page Department Important: If any injury or		4 Donation 5 Other (Specify) Cheltenham Veteran 4/1 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAI	LL BROT	THERS FUN	ERAL HOME
80529		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		•	Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Bilateral pneumonia Due to (or as a consequence of): Diabetic Ketacidosis			Onset and Death
*	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): HYPOXIA			
ate be executed hysicien and he burial-transit		resulting in death) Last Due to (or as a consequence of): d.			
Physicien: The law requires that the death certificate be this certificate has been signed by the attending physicieral director, page 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of di Month	elivery Day Year
uires that the de	by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute	to the cause of death? Probably 4 Unknown
The law require cate has been si page 2 should I	Completed		24a. Was auto perfo 1 \(\text{Yes} \)	psy prior to ormed? death?	autopsy findings available completion of cause of s 2 No
Physicien: The this certificate har all director, page	To Be			one) dence 6 □Other (Sp	eecify)
tending Pt death. stor: After th	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Colominad Caterminad 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 3 Work? 1 Yes 2 No 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Place of Injury 4 Work?		how injury occurred Street and Number or I	Rural Route Number,
UNION oltel or Attenctors after death rel Directors lied in by the		4 ☐ Homicide building, etc. (Specify)	City or To	wn, State)	
To the Hospitel or Attending within 24 hours after death in 17 the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation and death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation and death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation and death occurred at the time, date and death occurred at the time, date and date and death occurred at the time, date and date at the time, date at the time, date at the time, date at th	irred at the time,	date and place, and di	ue to the cause(s)
F3F8		I lann Pell no D37243	,	April :	7, 2006
THINA		and manner stated. 29b. Signature and title of certifier 29c. License number D 372 4 3 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) AMES In Fate 1525 Oveenway Centry 31. Date filed (Month, Day, Year) APR 1 0 2006	1 #20	07 Mi	20770
Sta Registr		APR 1 0 2006			

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 10:45 PM April John A. Williams, Sr. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spinos

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Sept. 9, 1933 Holy Cross Hospital Montgomery 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Yrs 72 Director 071-26-9685 Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Prince George's Hyattsville Marvland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 7006 - 22nd Ave. 20783 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, elc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced "neturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "no eny injury or other traumatic event, the Medis 2008. Elementary/Secondary (0-12) College (1-4or 5+) IBM Corp. Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Clydia Rice Junius L. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 - 22nd Ave., Hyattsville, MD Vernola G. Williams/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/11/2006 Middlehope, NY Cedar Hill Cemetery Stewart Funeral Home 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 ewo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

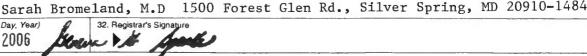
a. Pancreatic Cancer

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attanding physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Division of Vital Records. ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed? Yes 2 2 No the Hospitel or Attending Physicien: filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐XNo 1 X Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 □Natural 2 □ Accident 5 Pending death. investigation 1 Yes 2 No Director 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)

State

31. Date filed (Month, Day, Year) 0 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

D62571

April 4, 2006

			1 - For State Registrar		laryland				lealth an Death	d Mental H	Reg. No.		3 0 L 3		
П	Physic	an	1. Decedent's Name (First, Middle,	,						2. Date of D	Day	Year			
	/Medi	al	Catherine Coul 4a. Facility Name (If not institution,				4b City	Town	r Location of D	Marcl		County of Death	6:00pm M		
	Examir	er	14628 Chesterf		/				Lle,MD	oaur		Montgome	rv		
					ge (In vrs. I	ast birthday)	-	r 1 Year	If Under 24				place (State or Foreign ntry)		
	Funeral Director		577-12-7299 Usual Residence of Decedent	1□M 2፟MF	90	Yrs.	Months	Days	Hours N	Feb 2:	3,191	6 Was	hington DC		
	Maryland	tor	MD 10b. County Montgo	mery	1	Town or Lockvill							10d. Inside City Limits M Yes 2 □ No		
	h the	irec	10e. Street and Number				10f. Zi	p Code			10g. Cit	izen of What Cou	ntry?		
	th wit	aiD	14628 Chesterf	ield RD			2	20850			pecify Yes or No- o Rican, etc.) United Sta 14. Race - American Black, White, etc. Specify: White		tates		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural" or items 23s or 28s-f show amoning to other traumatic event, its Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces d 1 Tyes 2X If Yes, Give Year or Dates	?] No				lispanic Origin an, Mexican, P Specify:	? (Specify Yes or f uerto Rican, etc.)			etc.		
Maryland 21215-0036	hin 72 hour. In "natural" Madical Ex		15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)						ndustry		
12	withir ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 4	5+)	Teac			-/		Edu	cation			
9	filled Hygi Sther	ပိ									Education Name (First, Middle, Maiden Sumame)				
an	d be ental kad c	To Be	Gabriel Felix	Coulon					Minr	nie Maud	Shu1z	e			
ar.	shou nd M mar	J .	19a. Informant's Name/Relationsh	or Town, State, Zi	Code)										
Ž	nd 2 alth a 27 is		Cathy Carneval	e/ Daughter		1462	28 Ch	este	rfield	Dr., Roc	kvill	e,Md 208	350		
ē,	音音		20a. Method of Disposition		20b. P	lace of Dispendence	osition (Na matory or	ame of other pla	ce)	Date	20c. Lo	ocation - City or T	own, State		
E	Page 11 5		4 Donation 5 Other (Sp		9	tional			1	-5-06	Fa1	1s Churc	ch, VA		
Baltimore,	permit. Departminimporte		21. Signature of Funeral Service L	censee		2	2. Name a	and Addre	ss of Facility	Joseph Ga	wler'	s Sons,	INC		
	907 # Q		W. anthony	Murray	ad the death					Ave, N.W.		Ington Do	Approximate		
			23a. Part1. Enter the disease, of shock, or heart failure. List of	nly one cause on each	line.	i. Do not en	iter tile ille	de or dyn	ig, such as ca	raido or raspiratory	arrost,		Interval Between Onset and Death		
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Leuk										
	Examiner			Due to (or a	is a consequ	uence of):									
20	p #s	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b	is a consequ	uence of):									
	ecute and -trans	Каш	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	uance of):						-			
760,	ate be executed hysicien and the burial-transit	ical E		200 10 (0)		201100 0171									
687	9 %			d											
. Box	death cer e attendir ed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown 23c. If yes, outcome of pregnancy 23d. Date of 10 pregnancy 3 □ County 2 □ County 3 □									23d. Date of deliv Month	very Day Year		
P.0	that the od by detac	f.	Part II. Other significant conditio	s contributing to death	but not res	ulting in the	underlying	cause gr	ven in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?		
ds,	sign Id be	d by	Lymohoma							1[Yes 2	Mo 3 □ Pro	bably 4 Unknown		
Division of Vital Records,	Physicien: The law requires that the this certificete has been signed by the rall director, page 2 should be detached.	Completed								24a. W	as an topsy rformed?	24b. Were aut prior to c	opsy findings available ompletion of cause of		
=	: The	ပိ								1 ☐ Yes	2 X No		2 No		
Vita	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Off	205	Death (Check onl					
of	Physi this c	2	1 Yes 2 No	1 🗀 Inpa		ER/Outpatie		NOA	4 🗀 140131	ng Home 5 Re 28d. Describ			ity)		
ion	ding A. After fune	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	ation	Day Year)	Injury	M	28c. Inju Wo 1	rk?]Yes 2 □No						
Divis	or Atten after deat Director:	ertific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	200. Place Of I	Injury - At he etc. (Specif	ome, farm, s y)	treet, facto	ory, office		28f. Location City or	(Street a Town, Stat	nd Number or Ru e)	ral Route Number,		

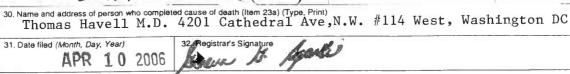
To the Hospital or Attending Physicien: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the at completely filled in by the funeral director, page 2 should be detached for

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 6 9 Unknown	al death 3 □Ectopic p			23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacco 1 ☐ Yes	24b. Were autopsy findings available
				autopsy performed? 1 ☐ Yes 27 N	prior to completion of cause of death?
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 🗆 Yes 2 🔼 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐D	OA Other: 4 Nursing I	Home 5, Residence	6 ☐Other (Specify)
27. Manner of Death 1 ≦ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Special	nome, farm, street, factorify)	ry, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
29a. Certifier 1 Certifying Fluid (Check only one) 2 Medical Example 1	iner: On the basis of my kin and manner stated.	owledge death critined ation and/or investigation	at the time date and place, in my opinion, death occ	and due to the cause urred at the time, date a	(s) and manner as stated and place, and due to the cause(s)
29b. Signature and title of certifier		29	c. License number	29d. D	Date signed (Month, Day, Year)
\	Atterno (1	6104 DC	Ap	ril 3,2006

State Registrar 31. Date filed (Month, Day, Year) 2006 10

Atterno



	Decedent's Name (First, Middle, Last) Date of Death								011	Death			Reg. No.	700	3. Time of Death
Physician		Elsa	Schiar	elli	Wrigh	t						April	Day 6	2006	5:00 p.
/Medical Examiner		ia. Facility Name (If						4b. City	Town, or	Location of	of Death	TIPILI		ounty of Dea	
		403 By	yrn Str	reet				(Cambr	idge				Doro	hester
uneral	5	5. Social Security No		6. Sex 1 ☐ M			last birthday	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Bir	thplace (State or Forei
ector	-	178-12-2! Usual Residence of		- I - IVI	aray.	88	Yrs.					Feb. 1	9,191	8 Pen	nsýlvania
=		10a. State	10b. County			10c. Cit	y, Town or L	ocation							10d. Inside City Limi
any injury or other traumatic event, the Medical Exactivet must be notified at once. To Be Completed by Funeral Director	5	MD	Dorch	ester	<u>-</u>				Camb	ridge	9				TXXYes 2 □ N
it, the medical Exertilization to the notified Completed by Funeral Director	1	10e. Street and Nun	mber					10f. Zij	p Code				10g. Citize	n of What Co	ountry?
a D	3	403 Byr	m Stre	et		21613						USA			
iner	1	11. Marital Status		12.	Was Decedent Armed Forces	t Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe						ecify Yes or No	- 14	Race - Ame	erican Indian,
V FL		1 Never Marrie	_	ied	1 ☐ Yes 2 🔀 If Yes, Give	INO 1 ☐ Yes 2 No Specify:									White
d b		3 Widowed			Year or Dates:										
Sete	_		15. Decedent ify only highes	st grade co.	mpleted)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)						ing	16b. Kind	of Business	/Industry
E O		Elementary/Secor	ndary (0-12)	(College (1-4or	5+)		Nur		,			ш	ealth	Como
BeC	1	17. Father's Name ((First, Middle,	Last)		18. Mother's Nam						(First, Middle			Care
<u>ි</u>	C	Cornelius	Schia	relli	Ĺ	Rosina Bert							ini		
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number,								er, City or T	own, State, .	Zip Code)				
5	_	Monica R. Wright Daughter 403 Byrn Street Cambridge, Maryland 210													
	2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Cemetery, crematory or other place)											Town, State		
1	L	`4 Donation	5 Other (S)	pecify)		Do	rchest				4/10	0/06	Cambi	ridge,	Maryland
any in	:	21. Signature of Fur	neral Service I	Licensee			2	2. Name ar l'homa s	nd Addres	s of Facilit eral	Home	P.A.			
a 0	ł	OCO COLO STATE	u j w	Jr.		1.00 - 1 - 1		YUU LK	CUST	Stre	et (ambrid	ge, Ma	arylan	d 21613
		23a. Pahl. Enter the shock, or hear		only one ca	ause on each l	d the death									
ian			FT: 1			line.	_ ~	ter the mot	de of dying	g, such as	cardiac o	r respiratory a	rest,		Approximate Interval Between Onset and Death
2		Immediate Cause (I disease or condition resulting in death)	Final n	_ a	End	Star	5º D	e nec	ae or dying	g, such as	cardiac o	r respiratory a	rest,		Approximate Interval Between Onset and Death
_		immediate Cause (disease or condition resulting in death)	Final n	(a	End Due to (or as	s a cons	Sence of):	e nec	ae or dying	g, such as	cardiac o	r respiratory a	rest,		Interval Between
er		disease or condition resulting in death)	n	a	End Due to (or as CCYChi	Star sacons	Sence of):	e nec	cizes	g, such as	cardiac o	r respiratory a	rrest,		Interval Between
er		disease or condition resulting in death) Sequentially list concary, each of the concary of the	nditions, madiata riying	a	End Due to (or as	Star sacons	Sence of):	e hee	ae or dying	g, such as	cardiac o	r respiratory a	rrest,		Interval Between
Examiner	i i	disease or condition resulting in death)	nditions, magnata rlying injury	a	End Due to (or as	States a conserve Val	lence of): Color Unice of):	2 Nec	ne or dying	g, such as	cardiac o	r respiratory a	rest,		Interval Between
Examiner	i i	disease or condition resulting in death) Sequentially list contains, and the cause. Enter Under Cause (Disease or it that initiated events	nditions, magnata rlying injury	a	End Due to (or as CCYChy Due to (or as	States a conserve Val	lence of): Color Unice of):	e hel	cizls	g, such as	cardiac o	r respiratory a	rest,		Interval Between
alcal Examiner	i i	disease or condition resulting in death) Sequentially list consumers to the consumers of t	nditions, magnata rlying injury	a	End Due to (or as CCYChy Due to (or as	States a conserve Val	lence of): Color Unice of):	a hel	ae or dying	g, such as	cardiac o	r respiratory a	rest,		Interval Between
dical Examiner	i i	disease or condition resulting in death) Sequentially list contact the cause. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent	nditions, module riving injury	a	End Due to (or as CCYChy Due to (or as	s a consequence of pregna	Defence of): Culor unice of): unice of):	Aco	cizle	g, such as	cardiac o	r respiratory a		d. Date of del	Interval Between Onset and Death
dical Examiner	i i	disease or condition resulting in death) Sequentially list configure, and the sequentially list configure, and the sequential list configure, and the sequents resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 (1 1 Yes 2 2 (1 1 1 Yes 2 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	n nditions, madian riving injury	a	End Due to (or as CCYCh Une to (or as Due to (or as	s a consequence of pregna 2 Fetal	lence of): Culor unce of): unce of):	2 We U A ⊂ (C i Els	ey -	cardiac o	r respiratory a		d. Date of del Month	Interval Between Onset and Death
् व hysician/Medical Examiner		disease or condition resulting in death) Sequentially list configure, leading to impause. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9	nditions, madiate ryving injury	a	Due to (or as Du	s a consequence of pregna 2 Fetal titime of di	lence of): Culor unice of): unice of): incy ideath 3[PECTOPIC PI	regnancy	ey-			230	Month	Interval Between Onset and Death
् व by Physician/Medical Examiner	P	disease or condition resulting in death) Sequentially list configure, and the sequentially list configure, and the sequential list configure, and the sequents resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 (1 1 Yes 2 2 (1 1 1 Yes 2 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	nditions, madiate ryving injury	a	Due to (or as Du	s a consequence of pregna 2 Fetal titime of di	lence of): Culor unice of): unice of): incy ideath 3[PECTOPIC PI	regnancy	ey-		23e. Did to	23c	Month contribute to	ivery Day Year
by Physician/Medical Examiner	P	disease or condition resulting in death) Sequentially list configure, leading to impause. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9	nditions, madiate ryving injury	a	Due to (or as Du	s a consequence of pregna 2 Fetal titime of di	lence of): Culor unice of): unice of): incy ideath 3[PECTOPIC PI	regnancy	ey-		23e. Did to	23c obacco use /es 2×1	Month contribute to	ivery Day Year othe cause of death?
pleted by Physician/Medical Examiner	P	disease or condition resulting in death) Sequentially list configure, leading to impause. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9	nditions, madiate ryving injury	a	Due to (or as Du	s a consequence of pregna 2 Fetal titime of di	lence of): Culor unice of): unice of): incy ideath 3[PECTOPIC PI	regnancy	ey-		23e. Did to	23cobacco use	Month contribute to	ivery Day Year
pleted by Physician/Medical Examiner		disease or condition resulting in death) Sequentially list configure, leading to impeause. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 in Yes 2 in Yes 3 in Yes 3 in Yes 3 in Yes 4 in Yes 3 in Yes 4 in Yes	nditions, modules riving injury .ast .pregnant months? No	a	Due to (or as Du	s a consequence of pregna 2 Fetal titime of di	lence of): Culor unice of): unice of): incy ideath 3[PECTOPIC PI	regnancy	ory -		23e. Did to 1 \(\text{\tin}\text{\tetx{\text{\te}\tint{\text{\text{\text{\text{\text{\text{\text{\ti}}\tittt{\text{\text{\text{\text{\text{\texi{\text{\text{\text{\texi}\text{\texit{\text{\texi{\texi{\texi{\texi{\texi{\texi}\texit{\tet{\text{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\texi{\te	23c obacco use (es 2)2() an sy rmed? 2(2() No	Month contribute to	ivery Day Year othe cause of death?
pleted by Physician/Medical Examiner	P - 2	disease or condition resulting in death) Sequentially list configure, and the sequentially list configure, and the sequentially list configure, and the sequential sequents resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown Part II. Other significant in the sequential	nditions, madianary riving injury	a	Due to (or as Du	s a consequence of pregnatut time of disputational contractions.	uence of): uence of): uence of): uence of): uence of): utting in the u	PEctopic pi ☐ Other (sp	regnancy poecify)	n in Part I.	of Death	23e. Did to 1 1 24a. Was autor perfo 1 1 Yes (Check only o	23cobacco use (/es 22N) an 2 sy rmed? 22No	Month contribute to No 3 Pr 24b. Were au prior to death? 1 Yes	ivery Day Year othe cause of death? obably 4 Unknow attopsy findings available completion of cause of
् व pleted by Physician/Medical Examiner	P	disease or condition resulting in death) Sequentially list contact the cause. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 ithe past 12 i	nditions, madians riving injury	a	End Due to (or as CCYCh Une to (or as Due to (or as If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown uting to death I	s a consequence of pregnatutitime of disput not resulted.	uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatie	Extopic pin Other (sp. underlying o	regnancy poecify)	n in Part I. 26. Place	of Death	23e. Did to 1 1 24a. Was autor perfo 1 1 Yes (Check only o	23cobacco use /es 22N an 2 sy rmed? 22N No	Month contribute to No 3 pr 24b. Were au prior to o death? 1 yes	ivery Day Year othe cause of death? obably 4 Unknow attopsy findings available completion of cause of
pleted by Physician/Medical Examiner	P	disease or condition resulting in death) Sequentially list configures. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12r 1	nditions, madians riving injury	a	Due to (or as Du	s a consequence of pregnatutitime of disput not resulted.	uence of): uence of): uence of): uence of): uence of): uence of): ER/Outpatie	Extopic pin Other (sp. underlying o	regnancy pecify) DA Other	n in Part I. 26. Place	of Death rsing Hon	23e. Did to	23cobacco use /es 22N an 2 sy rmed? 22N No	Month contribute to No 3 pr 24b. Were au prior to o death? 1 yes	ivery Day Year othe cause of death? obably 4 Unknow attopsy findings available completion of cause of
pleted by Physician/Medical Examiner	P	disease or condition resulting in death) Sequentially list contains. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown Part II. Other significations of the past 12 r 25. Was case referres examiner? 1 Yes 2 2 3 4 4 4 4 4 4 4 4 4 4 4 4	nditions. madiate riying riying .ast .pregnant months? .No .icant condition	a	Due to (or as Du	s a consequence of pregnance a consequence of pregnance at time of distribution to the consequence of pregnance at time of distribution to the consequence of pregnance at the consequence of the consequen	uence of): culor uence of): uence of): uence of): uence of): ER/Outpatie 28b. Time of Injury ome, farm, st	Ectopic pi	regnancy pecify) cause give	26. Place	of Death	23a. Did to	23cobacco use Ves 22N an sy rmed? 22N bence 6 C sow injury o	Month contribute to No 3 pr 24b. Were au prior to death? 1 yes Other (Spec	ivery Day Year othe cause of death? obably 4 Unknow attopsy findings available completion of cause of
pleted by Physician/Medical Examiner	P	disease or condition resulting in death) Sequentially list consumers and the consumers of	nditions, madiations, madiatio	a	Due to (or as Du	s a consequence of pregnal at time of distribution tresults.	uence of): culor uence of): uence of): uence of): uence of): ER/Outpatie 28b. Time of Injury ome, farm, st	Ectopic pi	regnancy pecify) cause give	26. Place	of Death	23e. Did to 1 1 2 24a. Was autor perio 1 1 Yes (Check only a	23cobacco use Ves 22N an sy rmed? 22N bence 6 C sow injury o	Month contribute to No 3 pr 24b. Were au prior to death? 1 yes Other (Spec	ivery Day Year othe cause of death? obably 4 □Unknow attopsy findings available completion of cause of
pleted by Physician/Medical Examiner	P 2	disease or condition resulting in death) Sequentially list contains to impact the contains to impact the contains to impact the contains the contains the contains the past 12 mm the pas	nditions. madiate riying riying .ast .pregnant months? No icant condition 5 Pending investig 6 Could in determi	d. 23c. 1 Hospination and be 21 g Physicial and be 21	Due to (or as CCYCL) Due to (or as If yes, outcome If yes, outcome If yes of the best United to (or as If yes, outcome If	s a consequence of pregna 2 Petal It time of distribution to result to the consequence of	uence of): uence	Ectopic pi	regnancy pecify)	n in Part I. 26. Place r: 4 \(\text{Nu} \) at ? e date are	of Death	23e. Did to 1 1 2 24a. Was autor period 1 1 Yes (Check only of the second of the secon	pbacco use (es 2) (an 2) an 2 an 3 sy med? 2 (a) No ne) dence 6 (a) an a	Month contribute to No 3 pr 24b. Were au prior to o death? 1 yes Other (Spec	ivery Day Year othe cause of death? obably 4 □Unknow attopsy findings available completion of cause of No city)
pleted by Physician/Medical Examiner	P 2	disease or condition resulting in death) Sequentially list contains. Enter Under Cause (Disease or ithat initiated events resulting in death) L FFEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown Part II. Other signifit 25. Was case referred aminer? 1 Yes 2 2 27. Manner of leath 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	nditions. modiate riying riying .ast pregnant months? No icant condition 5 Pending investig 6 Could n determi 7 Medical E	d. 23c. I d. Hospination not be gration and the gration active gration gration active gration gration active gration gration active gration gration active gration gration active gration active gration active gration active gration gration active gration gratio	Due to (or as CCYCL) Due to (or as If yes, outcome If yes, outcome If yes of the best United to (or as If yes, outcome If	s a consequence of pregna 2 Fetal titime of distribution trest but not rest but not	uence of): uence	Ectopic pi Other (sp. anderlying comment 3 DC) M reet, factory h occurred (vestigation	regnancy pecify)	26. Place 26. Place 4 \(\text{Nu} \) at ? es 2 \(\text{P} \)	of Death	23e. Did to 1 1 2 24a. Was autor period 1 1 Yes (Check only of the second of the secon	pbacco use (es 2) (an 2) an 2 an 3 sy med? 2 (a) No ne) dence 6 (a) an a	Month contribute to No 3 pr 24b. Were au prior to o death? 1 yes Other (Spec	ivery Day Year othe cause of death? obably 4 Unknow stopsy findings available completion of cause of No city)
ा क pleted by Physician/Medical Examiner	P 2	disease or condition resulting in death) Sequentially list contains. Enter Under Cause (Disease or ithat initiated events resulting in death) L IF FEMALE: 23b. Was decedent in the past 12 r 1	nditions. modiate riying riying .ast pregnant months? No icant condition 5 Pending investig 6 Could n determi 7 Medical E	d. 23c. I d. Hospination not be gration and the gration active gration gration active gration gration active gration gration active gration gration active gration gration active gration active gration active gration active gration gration active gration gratio	Due to (or as C C Y C S Due to (or as If yes, outcome 1	s a consequence of pregna 2 Fetal titime of distribution trest but not rest but not	uence of): uence	Ectopic pi Other (sp. anderlying comment 3 DC) M reet, factory h occurred (vestigation	regnancy pecify) DA Other Sause give at the tim, in my op License	n in Part I. 26. Place r: 4 \(\text{Nui} \) at ? fes 2 \(\text{Ninion, deat} \) number	of Death rsing Hon No	23e. Did to 1 24a. Was autor perfo 1 7 Yes (Check only of ne 3 Resid 28d. Describe h City or Tow and due to the ad at the time, of	pobacco use (es 2) An an sy rmed? 22(A No ne) dence 6 [anow injury o cause(s) an date and pla 229d. Date s	Month contribute to No 3 pr 24b. Were au prior to death? 1 yes Other (Special Course) Indiamanner as ace, and due signed (Month)	ivery Day Year othe cause of death? obably 4 □Unknow stopsy findings available completion of cause of item No city) iral Route Number, stated, to the cause(s) in Day, Year)
S should be detached for use as the burial-transit properties by Physician/Medical Examiner	P 2	disease or condition resulting in death) Sequentially list contains. Enter Under Cause (Disease or ithat initiated events resulting in death) L FFEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown Part II. Other signifit 25. Was case referred aminer? 1 Yes 2 2 27. Manner of leath 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	nditions. modiate riying riying .ast pregnant months? No icant condition 5 Pending investig 6 Could n determi 7 Medical E	d. 23c. I d. Hospination not be gration and the gration active gration gration active gration gration active gration gration active gration gration active gration gration active gration active gration active gration active gration gration active gration gratio	Due to (or as C C Y C S Due to (or as If yes, outcome 1	s a consequence of pregna 2 Fetal titime of distribution trest but not rest but not	uence of): uence	Ectopic pi Other (sp. anderlying comment 3 DC) M reet, factory h occurred (vestigation	regnancy pecify) DA Other Sause give at the tim, in my op License	26. Place 26. Place 4 \(\text{Nu} \) at ? es 2 \(\text{P} \)	of Death rsing Hon No	23e. Did to 1 24a. Was autor perfo 1 7 Yes (Check only of ne 3 Resid 28d. Describe h City or Tow and due to the ad at the time, of	pobacco use (es 2) An an sy rmed? 22(A No ne) dence 6 [anow injury o cause(s) an date and pla 229d. Date s	Month contribute to No 3 pr 24b. Were au prior to death? 1 yes Other (Special Course) Indiamaner as ace, and due	ivery Day Year othe cause of death? obably 4 □Unknow stopsy findings available completion of cause of item No city) iral Route Number, stated, to the cause(s) in Day, Year)
pletely filled in by the funeral director, page 2 should be detached for use as the burned call Certification; To Be Completed by Physician/Medical	P 2 2	disease or condition resulting in death) Sequentially list contains. Enter Under Cause (Disease or ithat initiated events resulting in death) L FFEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown Part II. Other signifit 25. Was case referred aminer? 1 Yes 2 2 27. Manner of leath 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	nditions. madianal rying riying injury .ast pregnant months? No icant condition 5 Pending investig 6 Could n determi Certifyin Could n Could n	d. c. d. 23c. I g. Hospi gation not be 24 gation not be 24 who complete who complete	Due to (or as Du	s a consequence of pregnal and a consequence of pregnal at time of did time of	Lence of): Culture of): uence of): uence of): uence of): uence of): uence of): ER/Outpatient 28b. Time of Injury ome, farm, str.) whedge, deattion and/or in	Extopic pi Other (sp Int 3 Do	regnancy pecify) Pause give Pause give	26. Place 26. Place 4 Nul at ? ées 2 N number 7 9 2	of Death rsing Hon 2 No 2 d place, ash occurre	23e. Did to 1 24a. Was autor perfo 1 7 Yes (Check only of ne 3 Resid 28d. Describe h City or Tow and due to the ad at the time, of	23c pobacco use /es 2 N an sy med? 2 No ne) tence 6 C now injury o cause(s) an date and pla 29d. Date s 4 - 7	Month contribute to No 3 Pr 24b. Were au prior to o death? 1 Yes Other (Special accurred Number or Ru dd manner as ace, and due	ivery Day Year othe cause of death? obably 4 □Unknow stopsy findings available completion of cause of item No city) iral Route Number, stated, to the cause(s) in Day, Year)

			1 – For Stata Registrar	State o	f Maryland		artment of Hetificate of E		d Mental Hy	giene	6	13045
	#		1. Decedent's Name (First, Middle, Las	1)					2. Date of De	eath		3. Time of Death
	Physici /Medic		Cecelia Ma	arie	Way				Month 0.4	04 20	Year 0.6	12:49p ^M
	Examir		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, Town, or	Location of D		4c. County		12.431
			Long View Nurs	sing H	lome		Manch	ester		Car	roll	-
Ĭs.	Funeral	(5)	Social Security Number 6. Security Number		7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da		9. Birthp	place (State or Foreign
	Director		101 03 7000	□M 2√2 F	96	Yrs.				-1909		PA
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Aary!	ō	MD Carro	11		mpste						1 ☐ Yes 2 ☐ No
	158 1 288 -	rect	10e. Street and Number			<u> </u>	10f. Zip Code			10g. Citizen of V	What Cour	
	Sa or	٥	4401 Sycamore	Drive			,	1074		-	SA	,
	er death with the Marylan Itame 23a or 28a-f show ont in unit be multified at	Funeral Director	11. Marital Status	12. Was Deci	edent Ever in U.S	S. 13. V	_ i		? (Specify Yes or No Puerto Rican, etc.)			can Indian,
	or Ita	Ρ̈́	1 Never Married 2 Married	Armed Fo	2 No				uerto Rican, etc.)		ck, White,	etc.
3	ral', c	ξ	¥☐ Widowed 4 ☐ Divorced	If Yes, Gr Year or D	ve lates:		☐ Yes 2 No	Specify:		Specify	" Wh	ite
	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	ent's Usual Occupa	tion uring most of	f workina	16b. Kind of Bu	usiness/In	dustry
1	ithin	np.	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done do OO NOT use retired)	g		_		
1	led w tygier her ti		17. Father's Name (First, Middle, Last)			HOI	emaker	40 34-45-31-	No. of Contract of the Contrac		Hom	.e
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or frame 23a or 28a-f show aumatic event, the Medical Examinar in this could be invitibled at	Be		scher				_	Name (First, Middle		16)	
<u> </u>	d Mer Marke narke	٩	19a. Informant's Name/Relationship (7			105 14-35-		Anna		erlein	O	2.11
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heaths and Mental Hygiens. Intropretair: It flam 27 is marked other than "natural", or Itame 23a or 28e 4 show any Injury or other traumatic event, the Medical Examinational Demonstrational approx.								or Rural Route Numb			ŕ
5	1 and Healt Bm 2 ther		Cecilia E. Demb	roskı			sition (Name of	e br	., Hamps	20c. Location -		
2	ages nt of nt of : If It		1 ☐ Burial 2 🔀 Cremation 3 🖂			emetery, cren	natory or other place)	22.0	200. Location	Only of 10	ANI, Otato
	rt. Parturer rtant		4 ☐ Donation 5 ☐ Other (Specify 21. Signaty of Funeral Service Licen		Ca	rroll	Cremati	ion 0	4-05-06	Hamps	tead	, MD
3	Depa Impo		21. Signature of Funeral Service Licent	7/	M005		Name and Address	Service Inc.	Eline F	uneral	Hom	e
	-Vine -		23a. Part1. Enter the isease, or comp	facts					t., Hamp		MD	ZIU/4 Approximate
			shock, or heart failure. List only of	ne cause on e	each line.	. Do not enti	ar the mode of dying	, such as car	l diac or respiratory a	irrest,		Interval Between Onset and Death
F	Medical		Immediate Cause (Final disease or condition resulting in death)	a	30000		VOITEN	7 0	ENDLIK.	6_		
	Examiner		1	Due to	(or as a consequ	ience of):		·				
		-	Sequentially list conditions,	b. Due to	(or as a consequ	ience of):						
	ted nslt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(
	arecu al-tra	Хаг	that initiated events resulting in death) Last	c	(or as a consequ	ience of):						
3	cate be executed physician and the burial-transit	dical		d								
	ficate p phy s the	edic		u								
5	eath certifi attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnar					23d. Dat	e of delive	∍rv
	death a atte d for	icia	in the past 12 months? 1 □ Yes 2 No	4□Pregn	ointh 2 Tetal nant at time of de		Ectopic pregnancy Other (specify)			Mo		Day Year
)	t the	hys	9 □ Unknown	9∐ Unkn	own							
	res that the de igned by the a be detached t	ру Р	Part II. Other significant conditions co	ntributing to de	eath but not resu	Iting in the ur	derlying cause giver	n in Part I.	23e. Did t	obacco use conti	ribute to th	ne cause of death?
ź .	w require been sig should b	ba	HTN Ar	Sins	λ ,	Den	entia		1 🗆	Yes 2XNo	3 Prob	pably 4 Unknown
3	law re	olet	,						24a. Was		Vere auto	psy findings available
2	The ta	Completed								psy ormed?	prior to coi death?	mpletion of cause of
3	ysician: The is certificate hadirector, page	0	25. Was case referred to medical					26 Place of	1 ☐ Yes Death (Check only of		Yes	2 L No
	ysic.	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	Inpatient 2 E	ER/Outpatien	Other	7	ng Home 5 Resi		er (Snecifi	v)
5	g Phys er this eral di		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of	28c. Injury Work	at		how injury occurr		/
2	ath. r: Aft	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(NOT)	iii, Day 16ai)	Injury		es 2 □No				
2	ar de recto by th	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At hor	me, farm, stre	eet, factory, office		28f. Location (Street and Numb	er or Rura	I Route Number,
5	safta safta al Dir	Certification:	normals	Dollar	ing, etc. (<i>Specily)</i>	,			City or 10	wii, State/		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attandeath. To tha Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phy	sician: To the	best of my know	viedge, death	occurred at the time	, date and pi	lace, and due to the	cause(s) and ma	nner as si	ated.
	the H in 24 the F plete	edical	one)	and mani	asis of examinati ner stated.	ion and/or inv	estigation, in my opi	mon, death c	occurred at the time,	uate and place, a	and due to	me cause(s)
ĺ	To T Com	Σ	29b. Signature and title of certifier	1 may	^		29c. License		5	29d. Date signed	(Month,	Day, Year)
0	7) Chamber	ZIIV			77 =	, , , , ,		4-4	-01	0
V	199		30. Name and address of person who c	ompleted caus			Print)	rala. L	minsto2	onn	21	157
,	4		m. PANSURIYA	34		colm	DK,	VVUI!	W 11/2/65	2 1011)	1 of	17/
	Sta Registr	100	31. Date filed (Month, Day, Year) APR 0 7 20		egistrar's Signati	K de	andis					
	A STATE OF THE STATE OF	4	711/01/20		-	1						

State of Maryland / Department of Health and Mental Hygiene 116

2	0	0	1	1
3	15	11	1	711
- 1	U	U	4.5	1

			Ola	to or mary		Certific				Reg. No.	10	13040
	Physici	an	1. Decement's Name (First, Middle, Last)						2. Date of De	ath Day	Year	3. Time of Death
and a	/Medi	cal	4a Facility Name (If not institution, give street/s	d number)				4b. City, Town, or l	Location of Deat		of Death	1. 17
1	Examir	ner	0 . 0	^				1 H.	1. Cl.	R	0	wre
-			5. Social Security Number 6. Sex	7. Age (Ir	yrs. lest bir	thday) If U	Inder 1 Year	if Under 24 Hrs.	8. Date of Bir	th		
	Funeral Director		212-50-3928 1 M 25		´- ^	Yrs. Mor	nths Days	Hours Min.	(Month, Da 11-09-	19. Year) -1946	Countr	ce (State or Foreign y) I'N
	pue 🗼		10a. State 10b. County	10	c. City, Tow	n or Location	1				10	d. Inside City Limits
	Veryt	ō	PA Adams		۸hh	ottst						1 ☐ Yes 2√€ No
	28.	Pec	10e. Street and Number		ממא		f. Zip Code		T	10g. Citizen of V	What Country?	
	3a or	Funeral Director	317 Tallahassee H	Blvd.			17:	301		11	SA	
	ms 2	Jere		s Decedent Even	r in U,S.	13. Was D		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No		e - America	
21215-0020	filed within 72 hours efter death with the Merylend Hygiene. ther than "naturel", or flems 23a or 28e-1 show thir, the Medical Examiner must be notified at	by	1 Never Married 23(2) Married 1 If Y	led Forces? Yes 2 √No es, Give ar or Dates:			specify Cub		o Hican, etc.)	Specify	ck, White, et Wh:	ite
5-0	ges 1 and 2 should be filed within 72 ho to f Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, if a Medical	Completed	15. Decedent's Education (Specify only highest grade comp	(atad)	16a.	Decedent's	Usual Occup	pation during most of wor d)	rkina	16b. Kind of Bu	usiness/Indu	stry
2	thin e	pje		lege (1-4or 5+)					King			
	filed withi Hygiene. Ather than	ပ္ပ	12			Tech	nicia				armad	су
Maryland	should be filed withind Mental Hygiene. marked other than Imatic event, tra M	Be	17. Father's Name (First, Middle, Last)						-	Maiden Surnam	10)	
y a	should be nd Mental marked or umatic eve	6	Milford Kins		dham							
<u>a</u>	2 sho		19a. Informant's Name/Relationship (Type, Prin	and Number or Ru				Code)				
	1 end Health em 27		Larry Johnson - So					St., Tar				
0	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	from State	cemete	Disposition ry, crematory	or other ple	ce)	Date	20c. Location -	City or Tow	n, State
Ë	T it is		4 ☐ Donation 5 ☐ Other (Specify)		Carr	011 C			04-07-0	6 Hamp	stead	l, MD
Baltimore,	permit. Pages 1 end Depertment of Health Important: if item 27 any injury or other tr pnce.		21. Signature of Funeral Service Licensee	MOC	550			^{ess of Facility} El Main St.		neral stead,		21074
	н,		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the	death. Do	not enter the	mode of dyi	ng, such as cardiac	or respiratory a	rrest,	1 1	Approximate nterval Between Onset and Death
1 Stan	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) a			ge L		Disease			1	Onset and Death
x 68760,	law requires that the death certificete be executed es been signed by the ettending physicien end a 2 should be deteched for use as the buriel-transit	√Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			consequence						
P.O. Box	res thet the death cer signed by the ettendir be deteched for use	Physician/M	Part II. Other significent conditions contributin	g to death but no	ot resulting in	n the underly	ing cause giv	ven in Part I.		tobacco use cor Yes 2□ No		the cause of death?
of Vital Records,	e law requires t hes been sign ge 2 should be	Completed by								an autopsy rmed?	avail	e autopsy findings lable prior to pletion of cause eath?
<u> </u>	The ete h	5							1 🗆	Yes 2 No	10	Yes 2000
/ita	ysician: The I s certificete he director, page	Be	25. Was case referred to medical examiner?					-14	ath (Check only	ne)		
2		2	1 ☐ Yes 2 No Hospital	1 Inpatient	2 ER/Ou	tpatient 3	J DOA			dence 6 □Oth		
2	in a line	ë	27. Manner of Death 1 Natural 5 ☐ Pending 28e.	Date of Injury (Month, Dey Ye	ar) 28b. 1	l'ime of njury	28c. Inju Wo		28d. Describe	how injury occurr	red	
Sio	Attanding or death. octor: Afte by the fune	cati	2 Accident investigation			М		Yes 2□No				
Division	or Att	Certification:	4 Homicide determined 28e.	Plece of Injury - building, etc. (S		rm, street, fa	ctory, office		28f. Location (City or To	Street and Numb vn, Stete)	er or Rural	Houte Number,
	ral D											
	To the Hospital or Attandii within 24 hours effer death. To the Funeral Director: A: completely filled in by the fu	edicai										
	within 2 To the comple	×	29b. Signature and title of certifier 29c. License number							29d. Date signed	d (Month, D	ay, Year)
	La		1/4/1/2			m	Do	59423	3	Aporil	7	2006
	ME?	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						7				
	4		Ndidi Fembera 560+ Loch Raven BIVD POB# 303						Bultimo	e mo	212	379
3	Sta	te	31. Date filed (Month, Day, Year) 37 Registrar's Signature							/		
	Registr	ar	APR 1 0 2006									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2006 **Physician** Year James Troy Weeden April 7, 2:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dealh Examiner 3805 Brightview Street Wheaton Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Month, Days Hours Min. Month, Day Yes Nov. 28, 5. Social Security Number 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign **Funeral** 3. 1918 457-18-2843 Mississippi Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show Maryland Montgomery Wheaton Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3805 Brightview Street 20902 USA Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after de. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items eny injuryed either traumatic event, the Medical Examinal page. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 DYes 2 □ No If Yes, Give 1941-71 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Midowed 4 ☐ Divorced 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Non-Commissioned Officer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Weeden Helen Birchfield 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony A. Weeden/ Son 3805 Brightview Street, Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Faith Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Cranesville, WV 21. Signature of Funeral Service Licen 26 Francis Adress Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Belween Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a Metastatic Carcinoma, Unknown Primary 4 Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ete has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Type II Diabetes Mellitus, 1 Yes 2€No 3 Probably 4 Unknown Completed Adenocarcinoma of Prostate 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has performed? 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2★XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30405 April 10, 2006 2+ Name and address of person who completed cause of death (Item 23a) (Type Print)
Paul A. Hemmer, M.D 6900 Georgia Avenue, NW, Washington, DC 20037 31. Date filed (Month, Day, Year)
APR 1 1 2006 32 Registrar's Signature

DHMH 17 Rev 1/2001

0:01

10d Inside City Limits

1 X Yes 2 No

Approximate Interval

Between Onset and

Death

2 No

this certificate has

Certification:

27 Manner of Death

Natural

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Carol Allan, MD

2 🗸 Accident

3

5 Pending

6 Could not be

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a)

e Hospital or Attending Physician: TI n 24 hours after death e Funeral Director: After this certifica letely filled in by the funeral director, pa Division of Vital To the I within 2 To the 1

Assistant Medical Examiner 32. Registrar's Signature 1000

28a. Date of Injury (Month, Day, Year) Apr 5, 2006

and manner stated

(Specify) Local Street

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

23:56

28c. Injury at Work?

29c. License numbe

O.C.M.E.

Yes 2 V No

28d. Describe how injury occurred

Driver motor vehicle collision

or Town, State) 24120 Frederick Rd, Clarksburg, MD

April 6, 2006

28f, Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

			1 - For State Registrar			of Mar	yland / D	epartmer Certificat	nt of H	lealth an		ntal Hy		nns.	1304	Q
)	Physici		1. Decedent's Nam Margue	, .	e, Last) Louis	e	Wyat	t.			2	Date of De.	Day	Year	3. Time of Dea	
	/Medio		·		n, give street and nu		, 45		Town, or	Location of D	Death	Apr 1		County of Deat		
	LXaIIII	**			8 & NURSI		NTER			, MD.)4		COMICO		
	Funeral		5. Social Security		6. Sex		In yrs. last birth	Months	r 1 Year Days	If Under 24 Hours	Hrs. 8	Date of Birt (Month, Da	h y, Year)	9. Birtl	nplace (State or For untry)	reign
- (Director		214-18-2		1 □ M 2 ½ F	93	3 Y	s.				0/2/19			yland	
	land		10a. State	10b. County		10	0c. City, Town	or Location							10d. Inside City Lin	mits
	Mary Ffeh fied	tor	Maryland	Wico	mico		Salis	oury							X □Yes 2□	No
1	in the	lrec	10e. Street and Nu	mber				10f. Zip	o Code				10g. Citize	en of What Co	untry?	
书	23a	Funeral Director	200	Civic	Ave.				2180					SA		
0	er de:	nue	11. Marital Status		12. Was Dec	orces?	er in U.S.	 Was Dece II Yes, spe 	dent of Hi cify Cuba	spanic Origin n, Mexican, F	n? (Specif Puerto Ric	Specify Yes or No- to Rican, etc.) 14. Race - An Black, Wt				
7	urs aff	by	1 ☐ Never Marr 3 ☐ Widowed		If Yes G	va		1 ☐ Yes	¥ □ No	Specify:		Specify: white			ite	
J 3	5-0050 72 hours after death with the Maryland natural', or tterne 23a or 28a-f ehow iseal Exemination at the multified at	ted	(Sne	15. Deceden	t's Education st grade completed)		16a. [ecedent's Usu	al Occupa	ation	f working		16b. Kind	d of Business/l	ndustry	
01 5	within 72 hours a giene. er then "natural", or er then "natural", or the matural	Completed	Elementary/Seco		College (Give kind of wo)	i working		Gl-	- 0		
7 5	filed v Hygie ther t	ပိ			Last)		130	ecretar	Y	18 Mother's	Name /	First Middle		e Compa	ıny	
الم الم	id be ental ked o	To Be	17. Father's Name (First, Middle, Last) Lawrence S. Williams Sr. 18. Mother's Name (First, Middle, Maiden S Ida C. Exall										arrame,			
9	Mal ylalla d 2 should be file th and Mental Hy ?? is marked oth traumatic event	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St										Town, State, Z	ip Code)		
b)	and and a n 27 in 127 i				y/daughte			511 Phe				-	, MD	21804		
Marguerite	Defititione, Wat yield A. I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, its Madeal Exeminar must be inclifted at once.				3 □Removal from pecify)		20b. Place of Cometery, Salisbu			e) 4/	Date /10/C			ation - City or 1 .isbury		
+ 0	permit. Departition of the permit of the per	(NOAM	Service	10	poo	CFSP	²² H811 501	oway Snow	* füner Hill	al H Rd.,	ome Pr Salis	ofes: bury	sional , MD 21	Associati 804	ior
			23a. Part1. Enter t shock, or hea	the disease, or art failure. List	complications that only one cause on	aused the	e death. Do no	enter the mod	de ol dying	g, such as car	rdiac or r	espiratory ar	rest,		Approximate Interval Between	
	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	_a. a.cu	10	M	gra	id c	al	4	for	1		Orser and Death	1
	Examiner						onsequence of	.							a 6 :	
		Jer	Sequentially list no if any, leading to in	nditions nmediate	b. X.C1	or as a co	onsequence of	- in		-1					10M7	
	cuted nd transit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events	injury s	c. 6	V.	in	1 2	-2	2 cm	10	4			1000-	
760	cate be executed physicien and the burial-transit		resulting in death)	Last	Due to	(or as a ci	onsequence of							/		
	physii	dlcal			d											
>	Attending Physician: The law requires that the death certifical death. Attending Physician: The law requires that the death certifical death. Sector: Alter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, ou								23	d. Date of deliv	/Arv	
à	death death e atte	Icla	in the past 12 1 \square Yes 2[months?	4 ☐ Pregr	ant at tim	Fetal death ne ol death	3 ☐ Ectopic pr 5 ☐ Other (sp						Month	Day Year	
0	that the dended by the a	hys	9 🗌 Unknown	1	9□ Unkn											
4	ries tha signed I be de	þ	Part II. Other signit	ficant condition	ens contributing to d	eath but n	not resulting in t	ne underlying o	ause give	n in Part I.				/	the cause of death?	
Š	w require been signature	etec									-					
ò	he lav e has ge 2 a	Completed									_	24a. Was autop	sy	prior to co death?	opsy findings availa empletion of cause	ol
•	ysician: The is certificate hadirector, page	Be Co	25. Was case refer	red to medical						36 Place of	Dooth (1 ☐ Yes	2 210	1 🗆 Yes	2 No	
2	Physicia Physicia this cert	To B	examiner? 1 ☐ Yes 2 🛈		Hospital:	Inpatient	2 ER/Outp	atient 3 DC	Othe	26. Place of				□Other (Spec	(v)	
5	ding Ph After th funeral		27. Manner of Deat	h 5 🗆 Pendin	28a. Date (Mon	of Injury th, Day Ye	ear) 28b. Tin	e of 2	28c. Injury Work			I. Describe h			-37	
	Mendii death. ctor: A y the fu	catl	2 Accident	investig	pation			М	1 🗆 Y	′es 2□No						
Division of Vital Becords D O Box 68	or Attendent after death	Certification:	4 Homicide	determ	ined 286. Place	ng, etc. (S	- At home, farm Specify)	, street, factory	y, office		281	City or Tow	itreet and i n, State)	Num <i>ber</i> or Rui	al Route Number,	
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	1 Certifyin 2 Madical	g Physician: To the Examiner: On the b and man	best of masis of example to the state of the	amination and/	eath occurred or investigation	at the time, in my op	e, date and p inion, death o	place, and occurred	I due to the d at the time, d	ause(s) ar	nd manner as a	stated. to the cause(s)	
	To the To the comp	ž	29b. Signature and	title of certifier	Anll			290	c. License	number	^	4	29d. Date :	signed (Month,	Day, Year)	
	13		1		Ithon			5	12,	934	1		4/5	1/06		
	Ca				who completed caus				<i>l</i>	(/		11			
	Sta	te	31. Date liled (Mon	th, Day, Year)			IC AVE. Signature	, SALIS	SBURY	MD.	218	04				
9	Registr	ar		APR 1 1	2006	MERC	· B.	goods.	,							
Г	DHMH 17 Rev 1/20	001					,									

DHMH 17 Rev 1/2001

06-02450	
Woolfok, Rhonda	

Physician/ Medical Examine

Funeral Director

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, MD 21215-0036

э	Sta		e Type or Pri and / Departm					ne	00		: C C F**
	1- For State Registrar		Certific	cate of	Death			Rea. N	. 201	16	1305
ın/	Decedent's Name (First, Middle,	Last)						of Death		3 Ti	me of Death
ner	Rhonda Nic	hole W	oolfolk				Mon Apri	th I 10, 2006		3:	:40
	4a. Facility Name (if not institution, Ft. Washington Hospita	_	umber)	4	b. City, Town, or Ft. Washin		Death	L	4c. County of Prin ce Ge		
	5. Social Security Number 6	Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Yea	r If Under 2	24Hrs. 8 Da	te of Birth (M	M/DD/YYYY)	9 Birthplac	e (State or Foreig
	214-19-8959	1 M 2x XF	25	Yrs.	Months Day	s Hours	Min. 0.8	8_04_	1980 N	Country)	229
	Usual Residence of Decedent		23	110.			100	,-04	1900 1	лагуг	and
	10a. State 10b. County		10c. City, Town	or Locati	on					10d.	Inside City Limits
_	MD. P.G.		Oxon	ម.1	1					1	Yes 2 X No
cto	10e. Street and Number		OROH	1111	10f. Zip Code			10g C	itizen of Wha	Country?	
ire	1101 Wilmett	a Drive			20745					-	
ᆵ	. 11. Marital Status		cedent Ever in U.S.	12 10/0		i- Orinia	2 (0if . V-		nited		
ner	1 Never Married 2 Mar	A 1 E			s Decedent of His es, specify Cubar				White,	American In etc.	dian, black,
Z		1 Yes ced If Yes, Give Yes	21 No	1	Yes 2 No	specify:			Specify:	Blac	k
<u>5</u>	15. Decedent's Education (Specif	or Dates:	-7	1	s Usual Occupa		id of work don	e 16b	. Kind of Busi	ness/Industr	7/
)tec	Elementary/Secondary (0-12)	College (durin	g	vorking life. DO N			100	. Kirid of Busin	ic sami agan	y
현	12th				Care		,	D	evelo	nman.	tal Car
Be Completed by Funeral Director	17. Father's Name (First, Middle, L	ast)				_	Name (First, N		-	pmen	car car
æ (Revelle Woo	olfolk				Cynt	hia A	. Str	ona		
2	19a. Informant's Name/Relationship	p (Type, Print)	19	b Mailing	Address (Stree	et and Numbe	er or Rural Ro	ute Number,	City or Town,	State, Zip (Code)
	20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spe 21. Signature of Funeral Service Li	cify:	om State 20b. Place crema	of Dispository or oth	ncoln	metery,	Date 04-21	-06 B	rentw	ity or Town,	State
	Lisa A. Henry (per 23a. Part I. Enter the disease, or co failure. List only one cause or Immediate Cause (Final disease	omplications that c n each line.		ot enter th	e mode of dying,	such as card	diac or respira	tory arrest, s	hock, or heart	App	 , ZOOO Z proximate Interval tween Onset and Death
	or condition resulting in death)	Due to (or as a	a consequence of):					pricuior			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	a consequence of);								
	events resulting in death) Last	Due to (or as a	a consequence of):								
edica	Xunpended	X AMENDED	item#21,23a	a,27,pe	erFH,ME,g8	355,5/11	/06 TT				
Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live b	and at time of death	2 Fet	al death 3 ner (S <i>pecify</i>)	Ectopic p	regnancy	. 2	3d. Date of de Month	elivery Day	Year
μŞ	1 Yes 2 No 9 V Unkn	9 OTKIK									
P.	Part II. Other significant condition	ns contributing to	o death but not resulti	ng in the u	nderlying cause (given in Part	I. 23e		o use contribu		
호							1	Yes 2	No 3	Probably	4 U nknown
mplete								a. Was an autopsy performed	prio	or to comple hth?	findings available tion of cause of
Š	25. Was case referred to medical				26 Place	of Death (C)	1 N heck only one		No 1	✓ Yes	2 No
	examiner?	Hospital: 1	Inpatient 2 🗸 ER/0	Outpatient		Other	lursing Home	500	dence 6	Other:	
<u>1</u>	1 ✓ Yes 2 No 27. Manner of Death			Time of In		ry at Work?			njury occurred	oulei.	
ertification: To	1 X Natural 5 Pendir 2 Accident Investi		n, Day,Year)			Yes 2 N		I WOIT GOOD	gary occurred		
ertific	3 Suicide 6 Could determ	not be	e of Injury - At home, f	arm, stree	t, factory, office b	ouilding, etc.		cation (Street Fown, State)	and Number	or Rural Rou	ute Number, City

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit completely filled in by the funeral director, page 2 should be deached for use as the burial - transit

State Registrar

31. Date filed (Month, Day, Year) APR 2 5 2006

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29b Signature and title of certifier

Ling Li, MD

and manner stated.





111 Penn Street, Baltimore, MD 21201

29a. Certifier (Check only one)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

One)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

April 10, 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 30 2006 1505 Baby Boy Weinstein January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days, Year) Sinai Hospital 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Yrs. Director 30 January 30 2006 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 res 2 No Director ALTIMORE TARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: WhIT 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) NA 0 6 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other eny injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PHANIE WEINSTEIN ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BlackSMITH MOTHER PHANIE WEINSTEIN 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 1 Burial 2 Cremation 5 Other (Specify) Hospital 3 Removal from State HOSPITAL 0 DISPOSAL 21. Schature of Funeral Service Licensee 22 Name and Address of Facility SINAI HOSPITAL OF BALT 2461 W KIELUPDERE AUR. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Prematurity /Medical Due to (or as a consequence of): **Examiner** Hydrocephalus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 1 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ➡ No 24a. Was an autopsy performed? certificate 2 1 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ဥ 1 TInpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 😾 No М investigation N/AN/A
Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

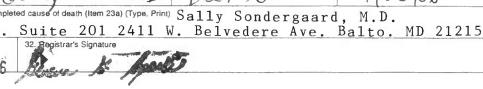
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

Office Bldg.

31. Date filed (Month, Day, Year)



127136

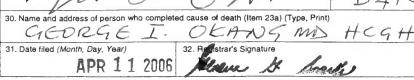
30166

M.D.

Division of Vital Records, P.O. Box 68760,

			Pleas	se Type or Pri				Ensure A	•	_		50
			1 - For State Ragistrar	State of iv	iai ytailu /		cate of			ag. No.	16 30	06
	Division		Decedent's Name (First, Middle						2. Date of Dea Month	th Day	3. Time of D	eath
	Physici /Medi		BARBAR	A La	WHIT	651	DE		APR		006 21:3	M ()
	Examir		4a. Facility Name (If not institution				•	r Location of Death		4c. County		
			HOWARD WUI	DIY GEN	HOSPI	M	COL	UmBI			UARD	
	Funeral Director		578-46-5123	6. Sex 7. A	ge (in yrs. last i 70		Under 1 Year inths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec 11,	1935	9. Birthplace (State or Country) Virginia	Foreign
	inyland ihow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location	n				10d. Inside City	
	e Ma	cto	MD Howa	rd	Elli	cott C	ity				1 ☐ Yes 2	
	ith th	Sire	10e. Street and Number			1	of. Zip Code			0g. Citizen of W	•	
	11 w	- R	4215 Buckskin W	ood Drive			21042	2		United	States	
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28s-f ahow any injury or other traumatic avant, the Madical Examinat must be notified at ONCE.	by Funeral Director	11. Marital Status 1 ☐ Never Married ② Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces ad 1 Tes 2X If Yes, Give Year or Dates:	? JNo		Decedent of H s, specify Cuba res 2□•No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		· American Indian, k, White, etc. White	
215-0036	n 72 hor	Completed	15. Decedent (Specify only highes	s Education grade completed)	16	Sa. Decedent'	S Usual Occup	ation during most of work d)	ang	16b. Kind of Bu	siness/Industry	
212	withii ene. then	Ę	Elementary/Secondary (0-12)	College (1-4or	5+)		emaker	4/		Own H	ome.	
	Hygi Hygi ther int,	ŭ	17. Father's Name (First, Middle, I			HOM	GIRANCE	18. Mother's Nam	e (First, Middle,			
an	od be	To Be	Alvin Lee Likin	-				Thelma C			-,	
Maryland	mark mati	ř	19a. Informant's Name/Relationsh		19	9b Mailing Ar	dress (Street	and Number or Rui			State Zin Code)	
Ma	d 2 s th ar trau trau		Herbert L. Whit								y, MD 21042	2
ē,	Hea Hea tem		20a. Method of Disposition		20b. Place	of Disposition	(Name of y or other place	. 1	Date	20c. Location - (City or Town, State	
2	ages ant of t: if i		H Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp					n Cem.4-1	3-2006	Highlan	d. MD	
Baltimore,	ertme orten injur		21. Signature of Funeral Service §		/M01044			- 1			Family FH I	'nC
Ba	permii Deper Impor		18 Jan Col	Jun - 1 V. X	FIOTO44						ity, MD 210	
			23a. Part1. Enter the disease, or	complications that cause	ed the death. D						Approximate	
	Discontinuo		shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.	_	1 -0	1-			Interval Betwee	
1	Physician /Medical		disease or condition resulting in death)	a. <u>Se</u>	PTI		hoc	10				
	Examiner			Due to (or as	s a consequenc	e oi):	ho	2000				
		er	Sequentially list conditions if any, leading to immediate	b. Due to (or as	s a consequenc	e of):	1-0	Tuck				
	nsit	i.	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00	nal	-162	Alie	10				
	xecu and al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as	s a consequenc	e of):	- Liter	n /				
60	be e sicier buri	-		Po	SPITE	abor	1 -	tailu	10			
68760,	phys s the	g		d.	1		1					
Box (death certificate be executed e ettending physicien and of for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy					23d Date	of delivery	
B	ette	cia	in the past 12 months?		2 Fetal dea at time of death		pic pregnancy er (specify)			Mon		ar
P.O.	that the de ed by the detached	lysi	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknown								
	that the		Part II. Other significant condition	s contributing to death	but not resulting	in the underl	ying cause give	en in Part I.	23e. Did tot	acco use contri	bute to the cause of dea	ith?
Records,	The law requires that the ste has been signed by th page 2 should be detache	ed by							1 🗆 Ye	s 2 No	3 Probably 4 Juni	known
8	w require s been si should b	jet							24a. Was a	n 24b. W	ere autopsy findings av	ailable
Re	The la	Completed							autops	ned? de	ior to completion of causeath?	se of
Vital	ifficet or, p	O	25. Was case referred to medical				·	26. Place of Deat		<u> </u>	Yes 20 No	
>	Physician: The law this certificete has be rel director, page 2 s	To B	examiner? 1 Yes 2 No	Hospital:	ient 2 ER/0	Outpatient 2	□ DOA Othe	ar .	me 5 Reside		r (Spacific)	
o	Physical controls		27. Manner of Death	28a. Date of Inj	ury 28b	. Time of	28c. Injun		28d. Describe ho			
on	th.	ţ	1 Natural 5 Pending 2 Accident investig		ay Year)	Injury N		k? Yes 2 □ No				
Division	f or Attanding effer death. Diractor; After in by the fune	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of In	jury · At home.	farm, street, f					r or Rural Route Numbe	or,
D	efter Oliva	Certification:	4 Homicide	building, e	tc. (Specify)				City or Town			
	o the Hospital or Attending Phithin 24 hours efter death. o the Funeral Director; After the		29a. Certifier Certifying	Physician: To the best	t of my knowled	ge, death occ	urred at the tim	ne, date and place.	and due to the ca	ause(s) and man	ner as stated.	
	a Ho 24 h a Fui letely	Medical	(Check only 2 Medical E	xaminer: On the basis of and mapners	of examination a	and/or investig	ation, in my or	pinion, death occur	red at the time, d	ate and place, a	nd due to the cause(s)	
	o tha	Me	29b. Signature and title of certifier	2)		29c. License	e number	2	9d. Date signed	(Month, Day, Year)	

State Registrar



29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of L			ne 2006	13053
Physic /Medi		Decedent's Name (First, Middle, La David	,	an, Jr.			2. Date of Death Month March 30,	Day V	3. Time of Death 6:40 A. M
Exami		4a. Facility Name (If not institution, give Southern Maryland Hsp.			4b. City, Town, or Clinto	Location of Death		4c. County of De	
Funeral Director		5/8 -84- 19 4 /	Sex 7. Ag XIM 2□F	e (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You October 3.	9. Bi	rthplace (State or Foreign country) shington, D.C.
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince C	George's	10c. City, Town or Lo		ict: Heigh	ts		10d. Inside City Limits 1. □ Ves 2 □ No
death with the Maryland me 23a or 28a-f show Lmust be notified at	Funeral Director	10e. Street and Number 1905 Winter Gre	en Avenue	1	10f. Zip Code	20747	10g.	Citizen of What C	Country?
72 hours after death	ρ	11. Marital Status 1 ↑ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XX es 2 □ ! If Yes, Give Year or Dates:	40	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 【XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: BI	ite, etc.
d within 72 hours aft giene. er than "neturel; or i the Modical Exerti	Completed	15. Decedent's Ec (Specify only highest gra	ducation ade completed) College (1-4or 5	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired,	ition luring most of work)	ing 16t	b. Kind of Business	s/Industry
uld be filed fental Hygie rked other	To Be Co	12th grade 17. Father's Name (First, Middle, Last) David Q	. Zimmerman,		Unemployed	18. Mother's Nam	e (First, Middle, Mai Marian Bro	N/A Iden Sumame) OKS	
and 2 should be flik alth and Mental Hy 127 is merked oth er traumatic eveni	-	19a. Informant's Name/Relationship (Linda Zimmerman (Sist	** :				al Route Number, Ci istrict Heig		
permit. Pages 1 and 2 should be filed within 72 hours after dei Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Iteme any injury or other traumatic event, Ina Medical Exercities and once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licentes)	y)	Chesapeake	c Cremetory,	Inc. Apri			Beltsville, M
permit. F Departmi Importar any injur		faut C.	milers	2		ace, N.E. V	washington,	D.C. 2001	
Physician /Medical Examiner	ner	23a Part1. Enter the disease, or composition of the control of the	a. A COVIR Due to (or as	a consequence of):					Approximate Interval Between Onset and Death
ficate be executed physician and st the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):					
death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
The law requires that the site has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the ur	derlying cause give	n in Part I.			the cause of death?
The law requires t ete hes been signe page 2 should be o	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Physician: The I this certificete he ral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Impatie	nt 2 ER/Outpatien	Othe	-	(Check only one)		
al or Attending Physical director: After this director: After this director director director.	Certification: T	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury Work' M 1 \(\text{Y}	at ?	me 5 Residence 28d. Describe how in 28f. Location (Street	njury occurred	
To the Hospital or within 24 hours after To the Funeral Director completely filled in b		29a. Certifier 1 Certifying Ph	building, etc	. (Specify) f my knowledge, death	occurred at the time	date and place	City or Town, St	rate)	actated
in the Hi in the Fi of the Fi ompleted	Medical	29b. Signa are and title of certifier	and manner sta	examination and/or inv	estigation, in my opi	nion, death occurr	ed at the time, date :	and place, and due Date signed (Mont	o to the cause(s)
96		Lund.) AMEND	MG PHYSICI	W D5	2900	03	3-31-2	006
20		30. Name and address of person who of MUSA MOMOH	completed cause of de MD 876	eath (Item 23a) (Type, I	C AV H	301 , LA	AND OVER	2, MO	20785
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					

Please Type or Print in Black Indelible Ink Edward Francis Allen State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 23, 2006 Medical Examiner Edward Francis Allen 1440 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 4 Harlow Court Cockeysville Baltimore County 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 1 X M 2 F Country) MD 215-42-5300 Nov. 25, 1944 61 Usual Residence of Decedent any 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 Yes 2 X No MD Baltimore Cockeysville , or items 23a or 28a-f shor must be notified at once. hours after death with the Maryland rector 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4 Harlow Court 21030 United States 11 Marital Status Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married White, etc. Yes 2 X No Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: White "natural". Specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hou
Department of Health and Memal Hygiene
Important: If them 27 is marked other than "nat
injury or other transmatic event, the Medical East during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Francis Allen Mary Dooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Marie Andrulonis - Dau. 2509 Hamilton Ave., Baltimore, MD 21214 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Burial 2 X Cremation 3 West Arundel rematory 4-27-2006 Odenton, MD Other Specify Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, ner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause Examin (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit sician/Medical tending physician a use as the burial -UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? 2 Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate Yes 2 1 🗸 Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 2 No After 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 1 V Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director; 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 24, 2006 30 Name and address of person who cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

APR 2

32. Registrar's Signature

		•	For State Registrar	State of Mar	-	partmei e <i>rtifica</i>			nd M		giene Reg. No.	06	3055	
	Physic		Decedent's Name (First, Middle, La							2. Date of De Month April	Day	Year 2006	3. Time of Deat	h M
	/Medi Examir		Dorothy Ann Atw 4a. Facility Name (If not institution, giv Montgomery Hosp	e street and number)	01150	1	Town, or	Location of	f Death		4c. Co	ounty of Death		
\$	Funeral Director		5. Social Security Number 6. S 218-24-2327	Sex 7. Age (In yrs. last birthda 79 Yrs.	y) If Unde	r 1 Year	If Under 2 Hours	Min	8. Date of Bird (Month, Da Dec. 3.	h v. Year)	9. Birth	y place (State or For intry) Yland	віgп
	e Maryland Sa-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom		Oc. City, Town or Gaither								10d. Inside City Lin	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene Item 27 ie marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number 9215 Hawkins Cre 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	amery Road 12. Was Decedent Ev Amed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	er in U.S.	20 3. Was Dece	D882 edent of Hi ecify Cubai	n, Mexican,	jin? (Spec , Puerto F	offv Yes or No	Unite	n of What Country Add Stat Race - Amer Black, White pecify: Wh	Ces ican Indian,	
21215-0036	filed within 72 ho Hygiene. other than "naturent, the Med call.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Gi	cedent's Usive kind of web. DO NOT	ork done d use retired,	luring most	of workin	g		of Business/li	·	
Maryland 2	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, the Ms	To Be C	17. Father's Name (First, Middle, Last Floyd B. Creger					Mar	gie	(First, Middle, Harner	Maiden Su	imame)		
Baltimore, Mar	permit. Peges 1 and 2 sh Depertment of Health and Important: If Item 27 ie m eny injury or other traum ance.		19a. Informant's Name/Relationship (E11a Mae Kessell 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	/Sister	921 20b. Place of Discometery, of Monocac	5 Hawl sposition (Na rematory or y Ceme 22. Name a Rocky:	kins ame of other place etery and Addres ille,	Cream A 2 s of Facility Inc.	ery pril 006 Rob	ert A. O West	Beal Pumph Mont	ersburg tion City or 1 lsvill rey Fu omery	, MD 20	and
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that call sed the one cause on each line.	ne death. Do not	enter the mo		TICEL Y	Tana	2005		5	Approximate Interval Between Onset and Death	
8760, 🗴	eath certificate be executed by the standing physicien and for use as the burial-transit and	Ical Examiner	Sequentially list conditions, if the leading terms list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence of):									
.O. Box 68	law requires that the death certificate be executed as been signed by the ettending physicien end 2 should be detached for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other (s					230	d. Date of deline Month	very Day Year	
Records, P.	w requires that been signed b should be deta	ompleted by Pt	Part II. Other significant conditions	contributing to death but	not resulting in the	e underlying	cause give	an in Part I.			Yes 2 🗓	No 3 ☐ Pro	the cause of death	own able
Vital Re	The ate h page	C	25. Was case referred to medical	L				26. Place	of Death	autop perfo	rmed? 2 No	prior to c death? 1 🗆 Yes	ompletion of cause 2□ No	of
of	ing Ph After th funeral	atlon: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time	e of	28c. Injury Work	4 🗀 1901	No 2	ne 5 Resident	how injury o	occurred		ce
Division	To the Hospitei or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	al Certification:	3 Suicide 6 Could not 8 determined	building, etc.	(Specify) my knowledge, de	eath occurre	d at the tim	ne, date and	d place, a	City or Tou	wn, State) cause(s) ar	nd manner as	ral Route Number,	
	To the Howithin 24 h To the Fur	Medical	(Check only 2 Medical Exa	miner: On the basis of e and manner state	xamination and/or	rinvestigatio	on, in my op 9c. License	oinion, deat	th occurre	ad at the time,	date and pl	ace, and due	to the cause(s)	
	- 3 + 8		30. Name and address of person the	completed cause of dea	ath (Item 23a) (Type	pe, Print)	D356	35			Apri	1 21,	2006	
V	10	ate	Joseph Kaplan, M 31. Date filed (Month, Day, Year)	D. 6001 M	uncaster 's Signature			, Roc	kvil	le, Mar	yland	2085	5	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No. 2 Date of Death Decedent's Name (First, Middle, Last) Month 3. Time of Death Yeer 10:04 A LADYMARY BUCHANAN 18 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Health care St. Agnes Baltimone NA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 ☐ M 2 🗷 F 85 Yrs. 217.18.5442 09.10.1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NA 1 Yes 2 No MO BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 22 S. ATHOL AVENUE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA NIA YRS 12 1H GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HAYES BUCHANAN VIOLA MAMIE BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK BUCHANAN (NEPHEW) 817 KEVIN RD. BALTO. MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. CALVARY BALTO. MD 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licensee Vaughn 5151 BALTO, NATE PIKE, BACTO, MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis days disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages Department of I Important: if its any injury or o

Physician

/Medical

Examiner

Director

Be Completed by Funeral

ဥ

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. and: if item 27 is marked other than "natural", or itams 23a or 28a-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

BUCH A NAN

Be Completed by Physician/Medical Examiner

Medical Certification; To

Bequeritially list currentions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	quence of):	ifficial a	oliti's	12 days
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic pr			23d. Date of delivery Month Day Year
Part II. Other significant conditions of Arrhythmia Cheronic ke				23e. Did tobacc 1 Yes 24a. Was an autopsy performed; 1 Yes 2 2 3	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?			· · · · · · · · · · · · · · · · · · ·	eath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ DC	Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 Suicide 6 Could not be determined		nome, farm, street, factory	r, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Pl (Check only one) Medical Exam	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and plac in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
30h Signature and title of certifier		200	License number	3 PDG	Date signed (Month Day Year)

Avenue

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00 32. Registrar's Signature

2MM, Vagin
31. Date filed (Month, Day, Pear)

APR 2 6 2006

			For State Registrar	State of	Maryland /		artmen <i>tificat</i>					giene 10g. No.	006		30	57
	*		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ıth Day	Ye	ar	3. Time o	
	Physicia /Medic		Frank Vincent Bo	olla							April	17,	2006		7:06	AM M
	Examin		4a. Fecility Name (If not institution, given	e street and num	ber)				Location of	of Death		4c.	County of I	Death		
			242 Margate Road	1				nerv:					altim			
	Funeral Director		187-16-2384	Sex 1 M 2 □ F	7. Age (In yrs. last 84	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Jan 17	Year)	22 P	Birthpla Count enns	sylvan	or Foreign nia
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation	·						10	d. Inside C	ity Limits
	laryli sho	ö			т.	. .	ville								1 🗌 Yes	2 1 No
	28a-i	Director	MD Baltimo	re		TUILET	10f. Zip		-			10g. Citi	zen of Wha	t Count	ry?	
	with sa or		242 Margate Ro	oad					21093				USA			
	ns 23	era	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. \	Was Deced	lent of Hi	spanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)		14. Race - /			
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, Ira Medical Exactinal must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 X Yes If Yes, Give			fYes, spek 1 □ Yes		n, Mexicar Specify:		Hican, etc.)		Black, V Specify:		ite.	
21215-0036	hour tural	d b	15. Decedent's 8			6a Dece	dent's Usua	I Occupa	ation			16b Ki	nd of Busin	ess/Ind	ustry	unk
2	n 72	Completed	(Specify only highest gr	ade completed)		(Give	kind of wo	k done d	turing mos	t of worki	ng	100.74			,	ann
2	withi ene. than	mg.	Elementary/Secondary (0-12)	College (1-	4or 5+)	san	itari	an								
0	Hygi Hygi Sther ent, I	C	17. Father's Name (First, Middle, Las						18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)			
an	2 should be and Mentai Is marked o	To Be	Vincent Bolla						H	elen	Andorka	a				
ary	should have	Γ,	19a. Informant's Name/Relationship	(Type, Print)	1						l Route Numbe					
≥,	and 2 alith a 27 i		Irene Bolla/spou	ıse		24	2 Mar	gate	Road	-	hervill			1093		
Baltimore, Maryland	Pages 1: ent of He nt: If Iten ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special Control of the Contr		ceme	e of Dispo etery, crer	sition (Nar natory or o	ne of ther plac	e)	D	ate	20c. Lo	cation - Cit	y or Tov	wn, State	
Balti	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked eny injury or other traumatic e 2002.		21. Signatur Suneral Suce Lice	Wade, D	rector		ate A		_		655 W.	Bal	timor	e St	treet	
۲			23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	one cause on ea	ich line.	Do not ent	er the mod	e of dyin	g, such as	cardiac o	r respiratory ar	rest,		III II z	Approxima Interval Be Onset and	tween
	Pnysician /Medical		disease or condition resulting in death)	a.	as a consequen									-	1700	1.77
	Examiner		Sequentially list conditions,	b												
	D #	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a cons = uen	ce of								-4		
	ecute and trans	me	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequen	an af\:								-		
8760,	ate be executed thysician and the burial-transit		1	7) 01 800	or as a consequen	ice oi).				•				7		
	physicate to the t	dica		_ d												
9 X	ding se as	/Me	IF FEMALE:	23c. If yes, out	come of pregnancy	/							23d. Date o	f delive	rv	
S. Box	The law requires that the death certific. He has been signed by the attending pl page 2 should be detached for use as I	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknowh	1☐Live bi	irth 2 Fetal de ant at time of deatl	ath 3	Ectopic pi Other (sp						Month		Ďay	Year
P. O.	that the ed by detacl	Ph)	Part II. Other significent conditions	contributing to de	ath but not resulting	ng in the u	nderlying d	ause givi	en in Part I	i.	23e. Did to	obacco u	ise contribu	ite to th	e cause of	death?
Records,	quires tha n signed uld be det	ed by		•							125	es 2	□ No 3[□ Proba	ably 4]Unknown
00	aw requir is been si 2 should	Completed									24a. Was		24b. Wer	re autop	sy findings	s available
æ	The lav	Eo					,, , ,				perfo	rmed? ≱€ No	dea	th?	2 No	
ita	an: rtifica	BeC	25. Was case referred to medical						26. Place	e of Death	(Check only o	(ne)	1			
>	Physician: this certific ral director.	To	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 Ir	npatient 2 ER	/Outpatier	nt 3 🗆 D0	Oth	er: 4 🗆 N	ursing Ho	me 5 Resid	denc <i>e</i>	6 □Other (Specify)	
0 1	ng Ph (fer th Ineral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of	of Injury h, Day Yeer)	Bb. Time o Injury		8c. Injun Wor			28d. Describe h	now injui	y occurred			
Sio	death. ctor: A y the fu	cati	Accident investigate 3 Suicide 6 Could not	ho -			М		Yes 2		28f. Location (S	Ctrant n	od & Jason In our	or Our	Courte Abu	-har
Division of Vital	tal or Attending is after death. at Director: After ed in by the fune	Certification:	4 Homicide determine	280. Place	of Injury - At home ng, etc. <i>(Specify)</i>	a, farm, st	reet, factor	y, office			City or Tox			or nurai	HOULE IVE	TIDOI,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext	hysicien: To the miner: On the ba and mann	best of my knowle asis of examination ner stated.	dge, deat and/or in	h occurred ivestigation	at the tin , in my o	ne, date ai pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manne place, and	er as st I due to	ated. the cause	(s)
	To the within To the comp	ž	29b. Signature and title of certifier				29		e number				te signed (A		Day, Year)	
ł			I hall has		MD			0:	73.40°	i			4/21/0	6		
			30. Name and address of person wh	completed caus	e of death (Item 23	3a) (Type,	Print)				1:					
	300		William Sharfm		7753 Fa	115	Kd:	स पा	2 6	me-1	10, Md	12	1093			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 9 6 7		egistrar's Signatur	A SO	Mas									

ORIGINAL

			= For Amend Item #5 per Registrar	State of Maryland / D FH G855 5/4/06	epartment of He Certificate of D	alth and Mental H <i>eath</i>	lygiene Reg. No. 006 13058
	Physicia		1. Decedent's Name (First, Middle, Last) M A C		BUSBN	2. Date of Month	Death Say Year 1/53P M
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number) Street	4b. City, Town, for L	ocation of Death	4c. County of Death
	Funeral Director		5. Social Sec 26 N6055 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs. 8, Date of	Birth Day, Year) 10, 1928 9. Birthplace (State or Foreign Country) FLORIDA
	ס		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	r 28a-f s	Director	MALYLAND N/ 10e. Street and Number	A	10f. Zip Code	TIMORE	1 ☑ Yes 2 ☐ No 10g. Citizen of What Country?
	death witi ms 23e o	Funeral D	517 LAURE 11. Marital Status	. Was Decedent Ever in U.S.	13. Was Decedent of Hisp	panic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show may injury or other treumetic event. The Medical Exaction Institute Incillial at Once.	ρ	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Specify:	Black, White, etc. Specify: BLACK
21215-0036	hin 72 ho s. sn "natur Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	tition 16a. I completed) College (1-4or 5+)	Decedent's Usual Occupati (Give kind of work done du- life. DO NOT use retired)	on ring most of working	16b. Kind of Business/Industry
	filed with Hygiene other the sent, the	Ве Сош	17. Father's Name (First, Middle, Last)	MI	1	OPERATOR 8. Mother's Name (First, Midd	SIVEETHEART CUP CO.
Maryland	should be and Mental smarked c umetic eve	ToB	CORNELIUS 19a. Informant's Name/Relationship (Type	BRO 19b.		NELLIE d Number or Rural Route Nur	mber, City or Town, State, Zip Code)
_	t and 2 s tealth an sm 27 ls		RENARD BUSE 20a. Method of Disposition	By (SON) 5	17 LAURE Disposition (Name of	NS ST. BALT	THORE 10, 21217
Baltimore,	Pages ment of Hant: If ite		20a: Magnod of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	/ cemeter	crematory or other place)	Bey 04-28-00	WOODLAWN, MD.
Balt	permit. Departr Imports any inj		21. Significant of Funesal Avice I censes	ons	Joseph H. I	and the same of th	eral Home Balhmone
	Pnysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.		such as cardiac or respirator	y arrest, Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of	f):		SASIE
	ped ssit	niner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of	r):	HSCOLPAL VIN	C 1 > L
60,	death certificate be executed e attending physician and d for use as the burial-transit	al Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of	f):	MELLITUS	
68760	rtificate t ng physi s as the b	Medical	d.		SIABLITES	Maccinal	
.O. Box	the death certific: y the attending pl ched for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year -
Δ.	wrequires that the de been signed by the s should be detached	ed by Ph	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause given		id tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Il Records,	The lay ate has page 2	Completed by				24a. W au pe 1 □ Ye	prior to completion of cause of death?
f Vita	Phyeicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1	spital: 1 Inpatient 2 ER/Out	Othor	26. Place of Death (Check on 4 ☐ Nursing Home 5 🔀 R	ly one) ` esidence 6 □Other (Specify)
Division of Vital	ling h. After funer	atlon: T	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. T	njury Work?		be how injury occurred
Divis	of or Attendia after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Locatio City or	n (Street and Number or Rural Route Number, Town, State)
	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	edical C					the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To the vithin To the compl	Me	29b. Signature and title of certifier	st S	29c. License	number	29d. Date signed (Month, Day, Year)
	H		30. Name and iddress of person who cor	\ \ -	3	5 7 5	Sill My House
	St Regist	ate "	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Sports	(2001) (21	the Minamed and Minamed
	. negisi	TUI	APR 2 6 200	U Jackster Jos &	1		

			1 - State of Maryland / Dep	partment of Health and leartificate of Death		ene g. No. 006	13059
	Physici	an	Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Stephanie	Bolger	Acril 1	9 2006	
	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Houp: tal	4b. City, Town, or Location of Deat Baltinore Citu	1	4c. County of Deat Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 M M F 7. Age (In yrs. last birthda	y) ff Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth 01/31/79	year) 9. Birt Mar	hplace (State or Foreign Ytand
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary B-f sh	tor	Maryland Baltimore CO. Baltimor	e			1 □ Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	ath w	ral	319 Stafford Drive	21228		USA	
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show empt iglury or other traumatic event. The Medical Examinat must be notified at once.	by Funeral	11. Marital Status 1 Amed Forces 1 12. Was Decedent Ever in U.S. 13 Armed Forces 1 1 Status 1 12. Was Decedent Ever in U.S. 13 Armed Forces 1 1 Status 1 12. Was Decedent Ever in U.S. 13 Armed Forces 1 1 Status 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl □ Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Bfack, White Specify: Whi	e, etc.
2-0	72 hor	sted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation we kind of work done during most of work	rking 1	6b. Kind of Business/	Industry
21215-0036	within 7	Completed	Elementary/Secondary (0-12) Coflege (1-4or 5+)	Homemaker	, Airig		
Q	filed v Hygle other 1	CO	12 th 17. Father's Name (First, Middle, Last)		ne (First, Middle, M	aiden Sumame)	
Maryland	fental rked c	To Be	Stephen R. Bolger	Darlene	M. Bolger		
lary	and N is ma			iling Address (Street and Number or Ru		•	(ip Code)
≥	l and lealth m 27 her tr		rather	Hammond Dr.#510 A			
Baltimore,	. Pages iment of the tant: If its		4 Donation 5 Other (Specify) @ Loudor			Oc. Location - City or Baltimore	
Bal	permit Depar Impor eny in			22. Name and Address of Facility Loudon Park Funera	1 Home Ba	ltimore MI	21229
	Physician		23 Past. Enter the disease, or complications that caused the death. Do not e shick, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	tory distress sy			Approximate finterval Between Onset and Death
	/Medical Examiner						
		ner	Caquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	carmii preumo	nia		one month
d	licate be executed physicien and s the burial-transit	Examiner	resulting in death) Last Due to (or as a co sequence of): Due to (or as a co sequence of): C. Due to (or as a co sequence of): Due to (or as a co sequence of): Due to (or as a co sequence of):	involeticiency by	robone		four years
58760,	sicien burial	al E	Due of as a consequence of).				
687	tificate ig phys as the	edical	0.				V/0
Вох	res thet the death certifi igned by the attending be detached for use as	Physician/M	In the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
P. O.	D 0 D	hysle	1 ☐ Yes 2 ☐ No 9☐ Unknown	Cuter (specify)			
	law requires thet the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	icco use contribute to	the cause of death?
9 0 0	e law requir has been s je 2 should	Completed	3		24a. Was an autopsy	24b. Were au	topsy findings available
<u>~</u>	± eged	Соп			performe		
Ę.	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	ath (Check only one)		
ō	Phys	. To	27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 INdising F	lome 5 Residen 28d. Describe how	ce 6 Other (Spec	ufy)
<u>o</u>	nding ath. r: Afte e fune	atlor	1	Work? M 1 □ Yes 2 □ No			
Division of Vital Records,	al or Attending Physicien: elter death. I Director: After this certifice d in by the funeral director, i	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnieury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours efter death. To the Funaral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Clack only one) ertifying Physician: To the best of my knowledge, deal class of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, dat	e and place, and due	to the cause(s)
\	To the To the Comp	Me	29b. Signature and title of certifier **Lie Tema** 10 Ph D 30. Name and address of person who completed cause of death (Item 23a) (Type Julie Louine 600 North Wolfe J: 31. Date filed (Month, Day, Year) APR 2 6 2006	29c. License number	290	d. Date signed (Month	, Day, Year)
	/		Multi Terma 10 Ph D 30. Name and address of person who completed cause of death litem 23a) (Typi	Mes-000	3 A	pril 19,	2006
	b		30. Name and address of person who completed cause of death intem 23a) (Typi Julie Losman 600 North Wolfe J:	brest Baltane	Man 14	1 7,20	2.
	Sta Registr		31. Date filed (Mogth, Day, Year) APR 2 6 2006	arle	1 way can	4 4 6	<u> </u>

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 23, 2006 Year Physician BATES MILTON 10:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2901 BOSTON STREET #408 BALTIMORE N/A | Months | Days | Hours | Min. | AUG. 24, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F Director 212-14-3645 84 Yrs. MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at MD 1 ¥ Yes 2 □ No Directo N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: if them 27 is marked other than "natural", or Items 23a any july or other treumatic event, Ite Medical Examination 2009. 2901 BOSTON STREET #408 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No WW I I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) HOME REMODELING CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BATES ADLFR LOUIS IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 BOSTON STREET #408 - BALTIMORE, MD 21224 PAULINE BATES / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WORKMEN'S CIRCLE CEM. 04/25/2006 4 ☐Donation ≠ 5 ☑ Other (Specify) DUNDALK, MD eral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) CANCELL -PANCREATIC META STATIF **Physician** (HTWOM F) /Medical Due to (or as a consequence of): Examiner Say antially littronefficient if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner sician and burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burital-transit completely filled in by the furneral director, page 2 should be detached for use as the burital-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical phys the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? To Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 27. Manner of Death

1 Matural
2 Accident
3 Suicide
4 Homicide

29a. Certifier

| Continue one of title of certifier 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) O 30. Name and address of person who completed cause of death (kem 23a) (Type, Print) ATTURE MD HORKIND BAYNE 31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 2 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician BOWER MARGARET A^{M} April 19, 2006 5:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2X F Yrs 578-30-9429 91 November 28, 1914 Director Iowa Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 🛛 No Maryland Montgomery Gaithersburg Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 16128 Orchard Grove Road 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u></u> White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked otf Be John Joseph Kennedy Lillian Margaret Tobias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Margaret B. Bulman/Daughter 16128 Orchard Grove Road, Gaithersburg, Maryland April 23, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of important: If any injury or once. Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signa of Fuperal Service Licensee 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. Marketest M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SPIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sicien and burial-transit The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown certificete has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 28 No 1 Tyes 2 No 1 ☐ Yes of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) t) After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Division** 1 Natural 5 Pending within 24 hours after death.

To the Funerei Director: Af
completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the i 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number n 30. Name and address of person who completed caus of eath (Item 23a) (Type, Print) SILVER SPRING ND 20902 GEORGIA AVE. 9801 MUFMURY MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			State of Maryland / Departr		-	_	
		•	_ FOF	icate of Death	Reg	ZIIIIb	13062
	-		Decedent's Name (First, Middle, Last)		2. Date of Death	_	3. Time of Death
	Physici /Medic		Gloria Jean Cheele	4	Month —	16 - 06	4.30 PM
	Examin			City, Town, or Location of Death		4c. County of Death	
3			LAUREL RECHONNE HOSP	Laurel M	0	P.C	>
春	Funeral			Under 1 Year If Under 24 Hrs. 8 onths Days Hours Min.	Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		May 12,	1941 Mar	yland
	yland Iow		10a. State 10b. County 10c. City, Town or Location	on ,			10d. Inside City Limits
	Man B-1 sh	ţo	Maryland Prince George's Laurel				1 ☐ Yes 2 💢 💢 o
	or 28	Director	10e. Street and Number	Of, Zip Code		Citizen of What Cou	ntry?
	ours after death with the Marylan rsi', or items 23s or 28s-1 show Exercities court be coultied at		9043 Contee Road #202	20708		.S.A.	
	er de:	Funeral		Decedent of Hispanic Origin? (Specis, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White,	
36	rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ⑤ ¾ lo If Yes, Give 1 □ Year or Dates:	Yes 2XXNo Specify:		Specify: Whi	+0
21215-0036	72 hours after death with the Maryland natural; or Items 23s or 28s-f show Jigal Exacinat must be notified at			's Usual Occupation	16	b. Kind of Business/Ir	
215	도 교육	ple	Elementary/Secondary (0-12) College (1-40r 5+)	's Usual Occupation d of work done during most of working NOT use retired)	1		
	filed with Hygiene ther the	Completed	01000 12	strative Assistan		Property M	lanagement
pu	d ta b	Be	17. Father's Name (First, Middle, Last) (unknown)	18. Mother's Name (First, Middle, Ma nown)	iden Sumame)	
Maryland	should be and Mental marked c	ဥ	· · · · · · · · · · · · · · · · · · ·	ddress (Street and Number or Rural		City or Tourn State 7i	Codo)
Z	Ta T			riendsville Rd.			yland 21531
ē,	s fand f Healt Itam 2 other		20a. Method of Disposition 20b. Place of Disposition	on (Name of Da	te 20	c. Location - City or T	own, State
E O	Pages ment of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 XMemoval from State County Church Ceme	Christian etery 4/20/	2006 Pi	ttsvlvania	County, VA
Baltimore,	artin orta			ame and Address of Facility and Indianal			
m	Depa Impo sny l	9. 9	/ M00770 31	3 Talbott Avenue	Laurel	, Maryland	1 20707
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	ne mode of dying, such as cardiac or	respiratory arrest		Approximate Interval Between
1	Priysician	W (Brain Injur	4.		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a cy sequence of):	1	1		
39		<u>.</u>	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):	ULR IACH	CARI	214 &	
7	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course Course (as a consequence of): that initiated events	APPEC	7	,	
v Č	te be executed ysician and e burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
760,		cai	d	·			
89	leath certificate t attending physi I for use as the t	Physician/Med	IF FEMALE:				
Вох	ath ce ttendi	lan/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ecto	opic pregnancy		23d. Date of deliv Month	ery Day Year
0	at the de by the a stached f	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Oth 9 Unknown	her (specify)			
<u> </u>	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th		Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobac	cco use contribute to I	he cause of death?
ecords,	uld be	d by	Chronic Obstructive Po	ulmonary diseas	1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
Ö	s been si	Completed		0	24a. Was an	24b. Were auto	opsy findings available
α	The lav	ШО			autopsy performe 1XYes 2	d? death?	ompletion of cause of
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death			
of V	S 5	10	1 ☐ Yes 2 No Hospital: 1 A Inpatient 2 ☐ ER/Outpatient 3	3 DOA Other: 4 Nursing Hom	e 5 🗆 Residend	ce 6 Other (Speci	fy)
		inol.	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	ld. Describe how	injury occurred	
isio	death. ctor: A rthe fu	icat	3 Suicide 6 Could not be 380 Blace of Injury. At home form street	M 1 Yes 2 No	tf Location (Stree	et and Number or Rur	al Route Number
Division	after Direction	Certification:	4 Homicide determined building, etc. (Specify)	factory, office	City or Town, S		ar riouse riumber,
	spite nours neral		29a. Certifier 1XXCertifying Physician: To the best of my knowledge, death occ	curred at the time, date and place, ar	d due to the caus	se(s) and manner as s	stated.
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Atte completely filled in by the fune	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	igation, in my opinion, death occurred	at the time, date	and place, and due t	o the cause(s)
	within To th	Σ	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)
			1 Munimum in	D0055861		4/16/06	
	Z.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	# 10			
1	U	ate	31. Date filed (Month, Day, Year) 32. Restrar's Signature	100			
	Regist		31. Date filed (Month, Day, Year) APR 2 6 2006 32. Restrar's Signature	with			

		,	1 - For State Registrar		Marylan		artmen tificat			and M		eg. No.	06	130	63
	Physici	an	Decedent's Name (First, Middle, Last	•							2. Date of Deat Month	Day	Year	3. Time of	
	/Medic		Meena Manickam				45 0%	T	f a satisfic a	(D = -15	Apri1	23	2006 ounty of Deat	6:07	Рм
	Examin	er	4a. Facility Name (If not institution, give						Location o				Montgo		
	5		Montgomery Hospic 5. Social Security Number 6. S		. Age (In yrs.	last birthday)	If Under		ville If Under:		8. Date of Birth				r Foreian
	Funeral Director			□м 2 X ДF	57	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month, Day Dec 26	Year 19	48 <i>co</i>	hplace (State o untry) India	, i orongin
	ס		Usual Residence of Decedent												
	how	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside Cit	
	Ba-f e	cto	Maryland Montgome	ery	Pot	tomac								1 🗋 Yes	2 M NO
	h with th	ai Dire	10e. Street and Number 11728 Lake Potoma	ac Drive			10f. Zip	Code 2085	4		1		n of What Co Lited S		
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other then "natural", or Items 23s or 28s-f show Important: if Itam 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic event, Its Medical Examinar must be notified at ODGs.	by Funeral Director	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? 2 📉 No	'	Was Decect I Yes, spec I □ Yes	offy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Race - Ame Black, White A pecify: In		-
21215-0036	72 ho natur	Completed by	15. Decedent's Ec (Specify only highest gra			16a. Dece	dent's Usua kind of wo	al Occupa nk done d	ation luring most	of working	ng	16b. Kind	of Business/	Industry	
12	within and the state of the sta	idu	Elementary/Secondary (0-12)	College (1-	4or 5+)		oo notus iter						Softwa	are	
N B	Hygie ther int, it	ပိ	17. Father's Name (First, Middle, Last)			Compi	1001	spec.			(First, Middle, I			116	
Maryland	id be ental ked o	To Be	Arunachalam Chett		aughter	-					alambal				
ary	shound Mind Mind Mind Mind Mind Mind Mind Mi		19a. Informant's Name/Relationship (ng Address	(Street a	nd Numbe	r or Rura	Route Number	City or To	own, State, 2	Zip Code)	
	and 2 alth a 27 io		Geeth Chettiar			11728	3 Lak	e Po	tomac	Dri	ve, Pot	omac,	Mary]	Land 208	854
ore,	of He of He fitam r oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Domousi from S	0	lace of Dispo	natory or o	ther place	9)	Apri.	1 2.6,	20c. Locat	tion - City or	Town, State	
<u>Ĕ</u>	Page Tent ant: if ury o		4 □ Donation 5 □ Other (Specify		tate	Cremat	gome	ry n, Ir	ic.	200		Beth	esda,	Marylar	nd
Baltimore,	permit. Depertiment Import		21. Signature of Funeral Service Licer	See See	M01420) RG 75	Name and Dert 1	d Addres A. Pui scons	s of Facility inphrey in Ave	Fune nue,	ral Home/ Bethesda,	Bethes Mary]	sda-Chev Land 20	y Chase, 814	Inc.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	used the death	h. Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	Meta	static	Breast	t Can	cer						Onset and I	Jeath
	/Medical Examiner		resulting in death)	Due to (o	ras a conseq	uence of):									
H	ZAGIIIIIO	16	Sequentially list conditions,	b. Due to in	rae a consequ	uanca afi:									
П	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	133323614											
	ad-tra	xar	that initiated events resulting in death) Last	c. Due to (o	r as a conseq	uence of):							_		
8760,	cate be executed physicien and the burial-transit	cai		d.									. 11		
89	tificat ig phy as th														
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed rideath. sctor: Atter this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		th 2 ☐ Fete nt at time of d	I death 3	Ectopic pr Other (sp					230	d. Date of deli Month		/ear
ر. ت	s that med b e deta	by Pi	Part II. Other significant conditions of	ontributing to dea	ath but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did tot	oacco use	contribute to	the cause of d	eath?
ğ	w require been sig should b										1 □ Y€	s 2 K)	No 3∏Pr	obably 4 □U	Jnknown
Division of Vital Records,	The law re ate has bei page 2 sho	Completed									24a. Was a autops perform	v	24b. Were au prior to death? 1 \(\text{Yes}	topsy findings a completion of ca	available ause of
/ita	clan: ertific ector,	Be (25. Was case referred to medical examiner?							of Death	(Check only on	e)			
<u>}</u>	hysi this c	၉	1 ☐ Yes 2 📉 No		patient 2				4 □ Nu	CONTRACTOR STREET	ne 5 Reside			ofy) Hosp	ice
ב	After After funera	o	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month	, Day Year)	28b. Time of Injury	м М	8c. Injury Work	rat ⊲? ∕es 2 🔲 !		8d. Describe h	w injury o	ccurred		
<u>is</u>	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not b		of Injury - At ho	ome farm str	-		105 2 🗀	-	8f. Location (SI	reet and N	lumber or Ri	ıra I Route Num	her
<u>≤</u>	efter Direction	Certification:	4 Homicide determined	buildin	g, etc. (Specif	y)	001, 120101	, omod			City or Town				2071
	To the Hospitel or Attending Physician: The law within 24 hours effect death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the to niner: On the bas and manne	sis of examina	wledge, death	occurred vestigation	at the tim , in my op	e, date an pinion, dea	d place, a th occurre	and due to the caled at the time, d	ause(s) an ate and pla	d manner as ace, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290	. License			2		-	n, Day, Year)	
			ノイイ	\sim	Wi	7		D3.	5635			Apri	1 24,	2006	
	0,		30. Name and a ress of pason who	completed cause	of death (Item	n 23a) (Type,	Print)			711112					
	\'		Joseph Kaplan, M	D. 600	1 Munca	aster N	1111,	Ro	ckvi1	1e, 1	Marylano	1 20	855		
	Sta		31. Date filed (Month, Day, Year)	2006	gistrar's Signa	ture	ceste	,							
	Registr	ar	APR 2 6	ZUUb	-										

		For State	State of Marylan		artment of H		Mental Hy	giene Reg. No. U	116	13064
R	19	Registrer 1. Decedent's Name (First, Middle, Last)			timoate or	Douth	2. Date of De		00	3. Time of Death
Physic	ian		ohn William	Coste	11o, Sr		April		06 Year	8:15 P M
/Med		4a. Facility Name (If not institution, give s		- 00500	4b. City, Town, o				inty of Death	0.13 1
Exami	ner	Manor Care Bethes				hesda			ontgom	0.837
and the same of		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthdav)	If Under 1 Year		rs. 8. Date of Bi			
Funeral Director			M 2□F 85	Yrs.	Months Days	Hours M	in. 8. Date of 8i (Month, Di March	9, Year)	l New	lace (State or Foreign ltry) York
96 4 96	-	Usual Residence of Decedent				1	riaren	J, 172.	I IICW	IOIK
/land		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
Many Heh	to	Maryland Montgomer	cy K	ensing	ton					1 ☐ Yes 2 🔀 No
the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	itry?
3a o	O	3616 Littledale Ro	oad		208	395		Unite	d State	es
Jeath The 2	Funeral	11. Marital Status	2. Was Decedent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or Ne erto Rican, etc.)		Race - Americ	an Indian,
The first	Ē	1 Never Married 2 Marned	Armed Forces? 1 X Yes 2 No WW				erto Rican, etc.)		Black, White,	etc.
Urs a	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Sp	ec <i>ify:</i> Whi	.te
2 ho	Completed	15. Decedent's Educ			dent's Usual Occup			16b. Kind	of Business/Inc	dustry
715 7 is 1 is 1	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life.	kind of work done DO NOT use retire	d) auring most of v	vorking			
T with a second	Eo	Clementary/Secondary (0-12)	1	Busin	ess Owne	r		Execu	itive S	earch
Maryland 21215-0036 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 1e marked other then "naturel", or r treumatic event, the Madical Exam	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Maiden Sui	name)	
id be size	To B	John Julias Coste	11o			Lilli:	an Bennet	:t		
shou mar	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street		Rural Route Numb		wn, State, Zip	Code)
Ma d 2 d 1 d 1 d 2 d 1 d 1 d 1 d 1 d 1 d 1 d 1 d 1 d 1 d 1	1	John William Coste	llo, Jr./Son	7801	Archbold	Terrac	e, Cabin	John,	Maryla	nd 20818
Hear Hear other		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		il 22,		on - City or To	
ages nt of refit		1 ☐ Burial 2 ☒ Cremation 3 ☐ R	amoval from State	-	natory or other pla Crematoriu			Rethe	sda. Ma	aryland
Baltimore, bermit. Pages 1 ar Department of Hea mportent: if Item: eny injury or other once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			. Name and Addre	200	70	Deeme	bua, in	ar y rana
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Importent: if item 27 is marked other then "natural; or iteme 23a or 28e-1 show eny lajury or other treumatic event, the Medical Examiner must be notified at once.		Mhefalte Ban	20 MO13	Ro Ro	bert A. Pu	mphrev Fu	neral Home Bethesda,	/Betheso Marylar	la-Chevy nd 20814	Chase, Inc.
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the deat							Approximate Interval Between
Physician		Immediate Cause (Final	Atheroscle	rotic	Heart Di	CA3CA				Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a conseq		neart bi	sease				
Examiner			Diabetes T							
700	P.	Sequentially list conditions, it any, leading to immediate	Due to (or as a conseq	J 1						
nsit	nin	cause. Enter Underlying Cause (Disease or injury	Hypertensi	on						
xecu rand	Examiner	that initiated events cresulting in death) Last	Due to (or as a conseq							
68760, Ificate be executed physicien and as the burial-transit	cai E									
phys	0	0								
	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregna	ancv				224	Date of delive	101
Box eath cert attendin for use	ian	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)	у		230.	Month	Day Year
P.O.	ysic	1 U Yes 2 □ No 9 □ Unknown	9 Unknown	oatii 5	_ Other (specify) _					
, P.O. I	문	Part II. Other significant conditions con	tobuting to death but not res	ulting in the u	nderlying cause on	ven in Part I	23e. Did	tobacco use	contribute to the	ne cause of death?
Cords, P w requires thet been signed to should be detail	by	Stroke, Prostate			, ,					ably 4 Unknown
ord requi	ted	beroke, froseace	Billargemene,	Renai	IMBUILI	crency	-	103 2211		
Aec le law has b	Completed						24a. Was	osv	prior to coi	psy findings available apletion of cause of
The The page	Į,						pert 1 ☐ Yes	ormed? 2 X No	death?	2 No
Vital F vician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?				26. Place of D	eath (Check only	one)		
of V Physic this ce al dire	2	1 ☐ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	ner: 4 Nursing	Home 5 ☐ Res	idence 6 🗆	Other (Specify	()
Division of Vital Records, to attending Physician: The law requirest after death. Director: After this certificate has been signed in by the funeral director, page 2 should be to be a fine by the funeral director, page 2 should be to be a should be a		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injui	ry at /	28d. Describe	how injury oc	curred	
ior ath. rr: Af	atic	2 ☐ Accident investigation		, , , ,		Yes 2 □ No				
Oivision or Attendated after death Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At his building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location	Street and N.	umber or Rura	l Route Number.
Div	eri	Λ	bundary, etc. (Special	,,			0.1, 0. 70	iiii, Olulo,		
pspit hours iners y fille			ician: To the best of my kno							
24 Fu	edical	(Check only 2 Medical Examir one)	er: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	opinion, death of	curred at the time	date and pla	ce, and due to	the cause(s)
Division of Vital Re To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Me	29b. Signature and little of certifier	-11		29c. Licens	se number		29d. Date si	gned (Month,	Dey, Year)
) / VANO	clay _		D53	691		Apri1	20, 2	006
241		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Tyne				P1		
3			6320 Democrac			sda. Mar	cvland 20	817		
W 7 NA C	tate	31. Date filed (Month, Day, Year)					- <i>j</i> = and = 0	J=1		
Regis		APR 2 6 20	67.	K SO	eve					

06-02456										
Doswell, Bernard										

Please Type or Print in Black Indelible Ink
State of Wald land Department or Health and Medital Hygrener fh g856 6-13-06 vt

		- For State Registrar		Certific	cate of	Death				Reg. No.	200	36	13065		
Physicia	_	Decedent's Name (First, Middle,Las	1)						2. Date of De Month	ath Day	Year		e of Death		
dical Exami	ner	Bernard Doswell							April 10,	2006		12:	30		
1		 Facility Name (if not institution, giv 1658 Dulano Ct. 	e street and number	r)	4	b. City, Tow Baltimo		tion of Death		4c. (County of D	eath			
Funeral Director		5. Social Security Number unk 6. Security Number 6. Security Number 6. Security Number 1 (1)		ge (In yrs. last bi	• •	If Under 1 Months		Under 24Hrs lours Min				Country)	(State or Foreign		
Birector			M 2 F	80	Yrs.				Aug 2	1, 19	25	MD.			
any		Usual Residence of Decedent 10a State 10b. County		10c. City, Tow	n or Location	on						10 d In	side City Limits		
* .					altimo							1 X	Yes 2 No		
·land -f sh	ţ	MD		106	altimo	10f. Zip Co	ode			10g Citize	en of What (
Mar. r 28a ed at	Director	10e. Street and Number 1658 Delano Cour	-			101. ZIP 00	21217	7		rog. Onize		SA			
outh the Maryland s 23a or 28a-f show i notified at once.		1z		A Francis III O	40.19/2	Desedent			nacify Vac or N	lo 1		ian Black			
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene Firen 27 is marked other than "natural", or items 23a or 28a-f shor r traumatic event, the Medical Examiner, must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Deceder Armed Forces		15. Was	es, specify C	cuban, M ex	dican, Puerto	Rican, etc.)	10-	 Race - American Indian, Black, White, etc. 				
or dea	F		1 Yes	2 X No	1	Yes 2 V	No soe	ecify:		5	Specify: black				
s afte	Ď	or Dates:									nd of Busine		unk		
hour "natu Exal	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)													
36 nin 72 than dical	ble														
5-0036 iled within 77 Hygiene 1 other than	E	17. Father's Name (First, Middle, Last	12								e (First, Middle, Maiden Surname) unlt				
215 be filed ntal Hy rked o	Be	Charles Doswel						Ethe]	l Morr	ris					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours af Operatment of Health and Mental Hygiene Important: Iftiem 27 is marked other than "natural injury or other traumatic event, the Medical Examin	0	19a_Informant's Name/Relationship (1	Ba. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rout								y or Town, S	State, Zip Co	ode)		
MD id 2 should but and m 27 is aumativ	-	Otis Conway/cous	in		221	enr (cose A	Avenue	Balti imore,	more,	MG 21	.223			
and and fealth item		20a. Method of Disposition		1	e of Disposi	tion (Name			Date	20c. Le	ocation - Cit	y or Town, S	State		
MOFe Pages I nent of H ant: If or other		1 Burial 2 X Cremation 3	- M	Rayy	natory or oth		orv	6-1	L 3-0 6	Bal	lto. M	id.			
- 4 9 E 2		4 Donation 5 X Other Specify		e l			_	_{acility} Jan	mes A. M	orton a	& Sons	F.H. 17	701 Laurens		
Balti permit. Departn Import injury		21. Signature of Fundral Service Licer	Tade Di	rector		ame and Ad	_	Boar	d boo v	V. Ba	itimo:	re Str	eet Stree		
Physician		23a. Part Enter the dispase, or comp	olications that cause	ed the death. Do	not enter th	.timor ne mode of c	e, ML dying, such	as cardiac	01 2121 or respiratory a	/ arrest, shoo	ck, or heart		oximate Interval		
/Medical		failure. List only one cause on e	ach line.									Betv	ween Onset and Death		
Examiner		Immediate Cause (Final disease a or condition resulting in death)	Atheroscleroti Due to (or as a cor		cular Disc	ease						1			
,		b	,	isequence or).											
	ē	Sequentially list conditions, if any, leading to immediate but to (or as a consequence of): Due to (or as a consequence of):													
	mine	cause. Enter Underlying Cause (Disease or injury that initiated													
d sit	Exar	events resulting in death) Last	Due to (or as a cor	nsequence of):											
executed an and al - transit	<u>e</u>	d				_		-0-1	1 106 10						
	edical	UNPENDED	AMENDED #1	5,16a&1	9a&b 1	Per A	na Bd	G854	4/26/0						
	. ₹	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo	come of pregnance	cy	tal do ath	3 F	ctopic pregn	ancv		23d. Date of delivery Month Day Year				
Box 68 death certif the attending	Physician	past 12 months?		at time of death		her (Specif		otopio progn	arroy						
30x death e atte	ysic	1 Yes 2 No 9 Unknow	n g Unknown		0 01	Her (opeon)	,,								
· 4 × 4		Part II. Other significant conditions	contributing to de	ath but not resul	Iting in the u	ınderlying c	ause given	in Part I.	23e. Dio	tobacco u	ise contribut	te to the cau	ise of death?		
P.O es that to gned b	ğ								1`	Yes 2	No 3	Probably 4	4 Unknown		
ds, equire een si	ted								24a. Wa		24b. Wei	re autopsy fi	ndings available		
cords, law require has been s	βe									topsy rformed?	prio dea		ion of cause of		
29 -	Completed								1 ✔ Ye	s 2 No	1 🗸	Yes	2 No		
Division of Vital Records, rat or Attending Physician: The law requirers after death. Directors. After this certificate has been seled in by the funeral director, page 2 should 1	Be	25. Was case referred to medical examiner?	Hospital:				-	Death (Check		7	- C				
hysic this	0	1 Yes 2 No			R/Outpatient				ing Home 5			Other: Scene	9		
of ing Pl After unera	Certification: T	27. Manner of Death 1 ✓ Natural 5 ☐ Rending	28a Date of I (Month, Da		Bb. Time of I		c. Injury at		28d Describ	e how inju	ry occurred				
ion tendi eath. tor:	atio	2 Accident Pending	tion				1 Yes	2 No							
Divisior pital or Attent ours after death neral Director: filled in by the	ific	3 Suicide 6 Could no	t be 28e. Place of	f Injury - At home	e, farm, stree	et, factory, c	office buildi	ng, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
pital ours a	Ser	4 Homicide determin	ed (Specify)							,					
Hos 24 hc Fun etely		29a Certifier 1 Certifying Physi	cian: To the best of	f my knowledge,	death occur	rred at the ti	ime, date a	ind place, an	d due to the c	ause(s) and	d manner as	s started.	-/->		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this centif completely filled in by the funeral director.	Medical	one) 2 Medical Examin	er:On the basis of e and manner state	examination and/o ed.	or investiga				at the time, da	t the time, date and place, and					
F # F ō	ž	29b. Signature and title of certifier				29c.	License nu	mber		29d. [Date signed	(Month, Da	y, Year)		
		1/1/1/1	71.				O.C.M.E	Ξ.		Apri	111, 200	6			
		30. Name and address of person who	completed cause	of death (Item 23)	a)										
-			ssistant Medica		111 Pe	enn Stree	t, Baltim	ore, MD	21201						
	tate	31 Date filed (Month, Day Year)	32. Regis	trar's Signature											
Regi		· · · · · · · · · · · · · · · · · · ·	Maria	, St. A	Joanse	8									
DHMH 17 Rev 1/		THIND U LOOK	No Contract	-	ORIGINA										
OCME 10/2003				,		-									



DHMH 17 Rev 1/2001 OCME 10/2003

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HARRIET S. DECKERT 4:24P APRIL 2006 /Medical 4a. Facifity Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN WOODS ROSSVILLE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. (Month, Day, April 12 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M **X**XF 85 Maryland Director 219~05~9404 Yrs. 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 Yes X No Maryland Baltimore Baltimore County Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5288 Millfield Rd. 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Year or Dates: Specify: White 1 Yes 2XXNo Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coffege (1-4or 5+) 10 yrs. Housewife Housekeeping-Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mentel 90 and Mentel ages 1 and 2 should by nt of Heelth and Menter: If item 27 is marked Herman A. Dunker Katherine Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5288 Millfield Rd. Baltimore, Maryland Edward C. Deckert (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
eny injury or ot 1)CXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4~27~2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Siquature of Funeral Service Licensee Cassanh Funeral Home MARCK 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Metastatio **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physicien and for use as the burial-translt The law requires thet the death certificate be executed Due to (or as a consequence of) by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year ned by the at a detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🜠 No ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical Medi 29b. Signature and Attle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D2 9485 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie MD 21061 1845 OAKWOOD MUNESES

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

6

21215-0036

Baltimore, Maryland

Box 68760,

Ö

Records,

Division of Vital

1

32. Registrar's Signature

				For State Registrar	State of	of Maryla		partmei <i>ertifica</i>			ind Me	ntal Hy	giene Reg. No.	UUD	13067		
		Dhuaisi		1. Decedent's Name (First, Midd)	e, Last)						2	Date of De			3. Time of Death		
	85	Physici /Medio		Donald Alfred 1		April					18 2006 10:55am [™]						
		Examir	ner	4a. Facility Name (If not institution			. 4			r Location o	f Death			County of Deal arkord	th		
		Funeral		Upper Chesapeal 5. Social Security Number	2 <u>e Mearcai</u> 6. Søx		rs. last birthda	y) If Unde	Air r 1 Year	If Under 2	24 Hrs. 8	. Date of Bi	rth	9. Bir	thplace (State or Foreign		
		Director		033-24-5875	1 X □M 2□F	70	Yrs.	Months	Days	Hours	Min. 0	(Month, Da	1935	Mas	sachusetts		
		pu 🗼		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or	Location							10d. Inside City Limits		
		Aarylan February February	ō						_						1 X Yes 2 No		
		ours after death with the Maryland rat', or items 23a or 28a-f ehow Examirer outst be notified	Director	MD Harf	ora	H	ivre de		p Code				10g. Citi	izen of What Co	ountry?		
		3a or		144 Bay Blvd. 21078 USA													
		oms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 1	3. Was Dec		lispanic Orig	gin? (Speci	fy Yes or No		14. Race - Ame Black, Whi			
a	36	or it	y Fu	1 Never Married 2 Mar	ried 1 17 Yes	2 🗌 No		1 ☐ Yes		Specify:				Specify:			
Q	Ö	hours tural!,	ed by	3 X Widowed 4 □ Divorced	Year or I	Dates: 1954		cedent's Us	ial Occup	ation			16h Ki	ind of Business	rite		
70	15	within 72 hours after ene. than "natural", or ite	Completed	(Specify only highe	st grade completed,		(G.	ive kind of w e. DO NOT	ork done	durina most	of working	7	100. 1	ind or business	oo amaaa y		
5	212	d with giene	E	Elementary/Secondary (0-12)	College	College (1-4or 5+) Asst			. Station Master			Amtrak			ilroad		
1055	pu	al Hy	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name (i	First, Middle	, Maiden	Sumame)			
	yla	Ment Ment	ဂ္	Clarence W. Dr								h Fall					
	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", a any injury or other traumatic event, <u>tra Medical Examones</u> .		19a. Informant's Name/Relations Donald A. Drol		Can		ailing Addres Bay Bl						or Town, State,	Zip Code)		
00/81	6	Heall tem 2		20a. Method of Disposition	er, 1/1		Place of Discemetery, of				Dat			ocation - City or	Town, State		
9	- E	ages ent of nt: if if		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		1 2(8(8	rhord			1	4/21/	06	Ahoni	deen. M	D		
8	Baltimore,	mit. F portar injui		21. Signature of Funeral Service		,10		Mitche									
1	m			sitainem.	Smith	-B0								iace, Mi	21078		
				23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the deach line.								•	Approximate Interval Between		
4		Physician		Immediate Cause (Final disease or condition	a chr	onic re	spirato	rus fa	ilure						Onset and Death		
	7	/Medical Examiner	9.	Due to (or as a consequence of):													
0														13 days			
7	V	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2.090	rcted									18 days-		
0	ó	executed in and rial-transit		that initiated events resulting in death) Last		(or as a cons									10 3413		
30 CO	8 60	icate be executed physician and s the burial-transit	dicai		d. Mes	entenic	venoo	eclusiv	e dis	sease	cardi	ovasu	Jai d	sease			
3	9	artifica ing ph e as ti		IF FEMALE:	1 1/4/0	pheral		Jar o	USUA	ne, i	atrial	Fibril	lation				
8	Вох	The law requires that the death certifit the has been signed by the ettending froage 2 should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2 F	etal death	3 ☐Ectopic		y				23d. Date of de Month	,		
8	0	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9∐Unki	nant at time o nown	of death	5 Other (s	ipecity)						,		
#800	٩.	es that It igned by be detac	y Ph	Part II. Other significant conditi	ons contributing to	death but not	resulting in th	e underlying	cause giv	en in Part I.		23e. Did	tobacco (use contribute t	o the cause of death?		
77	rds	w requires been sign should be	g p	Chronic obstrue	twe pulm	energy d	iseare	Heavy	SM	oker		1 🖸	Yes 2	□No 3□P	robably 4 Unknown		
رد	Vital Records,	law requ as been 2 shouli	plet	Atrial Fibrillation	n, History	at Myo	Cardio D	infarc	t, hyo	ertens	ien	24a. Was		24b. Were a	utopsy findings available completion of cause of		
ona	Ä	The lavate has	EO	Stroke seizu		estive						perf	ormed2 2 No	death?	s 2 No		
0	/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	al .		7000				of Death (Check only	one)				
ري 	_	Physi this c al dire		1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpa			4 (140				6 □Other (Spe	ecify)		
+		ding f h. After funer	tion	1 ☑Natural 5 ☐ Pendi	ng 28a. Date (Mo	ry M	Work?			ld. Describe							
Drole	Division	if or Attending Physicien: after death. Director: After this certifica d in by the funeral director. p	Certification: To	3 Suicide 6 □ Could	not be 28e. Plac	e of Injury - A	t home, farm,								lural Route Number,		
0	Dİ	s after of in b	Sert	4 Homicide determ	build	ding, etc. (Sp	ecify)					City or To	wn, State	9)			
		To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifyi	ng Physician: To th I Examiner: On the	ne best of my	knowledge, d	eath occurre	d at the tir	me, date an	d place, an	d due to the	cause(s) and manner a	s stated.		
		the H nin 24 the F	Medical	one)	and ma	nner stated.	mation and o				ur occurred	at the thic					
		To will	-	29b. Signature and title of certify	1			2	Cicens	number	050	2		te signed (Mon	*		
		الم		30. Name and address of porson		VSICIAN	Itam 22a) /T-	ne Print	0	UWA	00	0	7	10/200	· 6		
		17		MARYAM JAGGR	· ·	I South	,		uite a	202 1	TAVES	DE 9x	EACE	MD 2	1078		
	-45	St	ate	31. Date filed (Month, Day, Year) 32	Registrar's Si				w t		y - J.	-77-00				
	138	Regist	rar	APR 2 6	7006		10 1										

			For State Registrar	State of N	/larylan		artmen		ealth and N Death	Mental Hy	gien Reg. N		13068		
	Dhorie		Decedent's Name (First, Middle, Last) 2. Date of Death										3. Time of Deat	th	
	Physici /Medio		Elmer Charles D	ahlweiner						April	}	8 2006	10:20 8	М	
	Examir		4a. Facility Name (If not institution	give street and number	0 - 1	1.1	4b. City,	Town, or	Location of Death			c. County of Deat	h		
			SAINIAC	nes Ho	SPIT	AL	BA	1271	MORE	T		/a			
	Funeral Director	Н	5. Social Security Number 219-01-7455	6. Sex 7. A 1⊠M 2□F	Nge (In <i>yrs</i> . 85	last birthday) Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Feb 9,	rth ay, Year 19:	9. Birt	hplace (State or Formunitry)	eign	
			Usuaf Residence of Decedent		- 05					reb 9,	19.	21 Mary	Tand		
	yland		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Lin	nits	
	e Ma	çç	MD N/A		Ba1t	imore							1 ☐ Yes 2 ☐	No	
	or 28	Olre	10e. Street and Number				10f. Zip				10g. C	itizen of What Co	untry?		
	ath w	rai	2426 Christian				212				U.S				
	ier de Item	inne	11. Marital Status 1 □ Never Married 2√3√Marri	12. Was Deceder	5?	.S. 13.	Was Deced ff Yes, spec	ent of Hi ify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	ncan Indian, e, etc.				
36	irs af	by Funeral Director	1 ☐ Never Married 2万Married 1万Mes 2 ☐ No If Yes, Give NOV 42 1☐ Yes 2万No Specify: Year or Dates: Dec 45								Specify: White				
Ō	within 72 hours after death with the Maryland ene. Than "naturel", or Itema 23a or 28a-f ehow he Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business.								ndustry				
21	thin 7	npie	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT us	e retired))	ang					
21	e filed within al Hygiene. I other than vent, the Me	Co	6			Machi	inist					Copper	Co.		
pue	12 should be filed who and Mental Hygie 7 is marked other tireumatic event, in	Be	17. Father's Name (First, Middle, I						18. Mother's Nam						
<u> </u>	hould d Me mark matic	၉	Joseph J. Dahlw 19a. Informant's Name/Relationsh			10b Maili	ing Address		Elizabet and Number or Rui				. 0.4.)		
2	s 1 and 2 should be filed within 72 hours after death with the Marylan fi Heelin and Mental Hygiene. I them 23a or 28a-f show them 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at		Doris Dahlweine										ip Code)		
ون	F Hee		20a. Method of Disposition	r/wire	20b. P	Place of Dispo	osition (Nam	e of	Street	Daltimo Date		ocation - City or	Town, State		
ê	Page ent o nt: If ry or		DOMBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		8	emetery, cre. .don Pa			"ry 4-22	-2006	Ba1	Ltimore,	MD		
Baltimore, Marvland 21215-0036	permit. Pages 1 and 2 Department of Heelih a Important: If Item 27 is eny injury or other tre page.		21. Signature of Funeral Service L		0.	2:	2 Name and	d Addres	s of Facility						
<u> </u>			Danielly	Marche	ety		328 S	e ru u1ph	neral Ho ur Sprin	me, Inc g Rd. A	rbut	us MD 2	1227		
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications hat cause only one cause on each	ed the deat	h. Do not en	ter the mode	of dying	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between		
	Physician		fmmediate Cause (Final disease or condition				Onset and Death								
	/Medical Examiner		Due to (or as a consequence of):												
		- G	Sequentially list conditions, if any, leading to immediate b. Congestive Heart for luve Due to (or as a consequence of):									1 year	,		
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Renoul failure									Hear	,		
Mo	exec exec	Exa	resulting in death) Last	Due to (or a	- 1 (uence of):	, 00, 1								
≥ 928	ate be executed hysicien and the burial-transit	Icai		Ca. H	yper	ten	Sior	`					lyear		
7/99	certifica ding ph	Med	IF FEMALE:		<i>J</i> '										
1779	eath certifica attending ph for use as t	by Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 🗆 Feta	I death 3	□Ectopic pre					23d. Date of deli	very Day Year		
3∘	, ō o ō	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐ Unknown	at time of di	eath 5L	Other (spe	ecify)							
40	requires that the	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cau				
# 5	quires on sign			T						10	Yes 2	!□No 3□Pro	bably 4 Unkno)WN	
V 8	faw reques been 2 should	Completed								24a. Was		24b. Were au	opsy findings availa	able	
	The lavele between the second	mo.								auto perfo 1 ☐ Yes	òrmed?	death?	ompletion of cause	of	
/ita	uclan: Th certificete rector, pag	Be (25. Was case referred to medical examiner?					Section	26. Pface of Deat		-				
Vio	Physician: this certificanal director.	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 Dinpar		ER/Outpatier			4 Norsing Inc			6 ☐Other (Spec	ify)		
0) 5	ding P h. After funera	ion	27. Manner of Death 28a. Date of fnjury 28b. Time of Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred Work? 1 Yes 2 No												
	Attend death ctor: A y the f	licat	2 Accident investig 3 Suicide 6 Could n determi	ot bo	niury - At ho	ome farm str			9S 2 140	28f Location /	Street	nd Number or Ru	ra / Route Number.		
Ş	afor after Dire	Certification;	4 Homicide	ned 28e. Place of le	etc. (Specif)	y)	ioot, idolory,	OTTIOG		City or To			ar riodia reditibar,		
17	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 ☑ Certifying	Physician: To the bes	t of my kno	wledge, deat	h occurred a	it the tim	e, date and place,	and due to the	cause(s	and manner as	stated.		
177	the H	Medical	(Check only 2 Medical E	xaminer: On the basis and manner s	or examina	tion and/or in	vestigation,	in my op	inion, death occur	red at the time,	date an	d place, and due	to the cause(s)		
	To the within To the	Σ	29b. Signature and title of certifier	L Ø			29c.	License	number		29d. Da	ite signed (Month	Day, Year)		
	14.		Mann.	4.1				17	514		(lirche	18th 20	306	
	57		30. Name and address of person v	who completed cause of	death (Item	23а) (Туре,	Print)	- 10	ve B	~ 1 L		. A A A	2122	4	
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signa	ture A	19 -		ve / 15	u i m	V	1-IMD	7177	4.	
	Registr		APR 2 6 2		1	1000									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#10e, perFH, 354, 4/26/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 21, Day 2006 **Physician** Year DIAMOND 11:12 P M ISADORE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CHARLESTOWN RETIREMENT COMMUNITY CATONSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. NOV. 16, 1923 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**☑** M 2□ F Months NE 82 Director 505-16-2911 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits r than "natural", or Items 23s or 28s-f ehow the Medical Exempler must be notified at Completed by Funeral Director CATONSVILLE 1 Yes 2 No BALTIMORE 10e. Street and Number
Maiden
709 MMAIDEN CHOICE LANE 10f. Zip Code 10g. Citizen of What Country? 21228 USA Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23 ury or other traumatic event, the Medical Exemplinar must 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **STAGEHAND ENTERTAINMENT** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **EUSAY** DIAMOND SARAH HILL ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA BAKER / WIFE 7701 E. BALTIMORE STREET - BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Department of Important: If any Injury or once. 04/25/2006 MT. CARMEL CEMETERY LINCOLN, NE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funefal Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1. Tanoscherotec Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by welletin 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After th funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending 1 Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) VQ UI within 24 hours after To the Funerel Dire 4 ☐ Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the cause of the time of the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0000040 Chariclan Calquarille 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) arden VA 45 32. Registrar's Signature State

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 Month Year **Physician** P^{M} April 19, Yacoub Lucy Damirji 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)

July 17, 1919 Turkey Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖔 F 212-13-4957 86 Yrs. Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-1 show the Medical Exeminer must be notified at 1 XYes 2 ☐ No Maryland Montgomery Gaithersburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 832 Quince Orchard Blvd, #102 20878 Lebanon Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Seamstress Clothing Business pelij 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: if item 27 is marked oth eny linury or other traumatic event page. 18. Mother's Name (First, Middle, Maiden Surname) Ibrahim Jalek Mariam Alajaji 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colette Sabbagh /Daughter 15678 Cliff Swallow Way, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 24, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 2006 21. Signatury of Fundial Service Licensee Robert A. Purphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Unix et Dayset M01305 23a. Part1. Emil r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small Bowel Obstruction Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to (or as a nonsequence of). and al-transit The law requires that the death certificate be executed Due to (or as a consequence of): ettending physicien a I for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe page 1 Yes 2 No 1 ☐ Yes 2 X No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕅 Inpatient 2 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending М 1 □ Yes 2 □ No investigation 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) δ 4 Homicide within 24 hours e To the Funeral C 29s Conflor 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D0063195 April 20, 2006 ŋ 8600 Old Georgetown Road, Bethesda, Maryland 20814 S. Wilks, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Amend item#10b,perFH,C834,4/26/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** LLL10 T DWIARD APRIL 2 2006 /Medical 4c. County of Death a. Facility Name (If not institution, give street and number) 46 City, Town or Location of Death Examiner WS BALTIMORE 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days Months 1**⊠**M 2□F Hours 79 217. 20. 8669 Director 02-21-1927 WEST INDIES Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show aumstic event, if a Medical Examilinat must be notified at Baltimore GWVNN 1 Tyes 2 K No Director MO GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 927 MASEFIELD ROAD 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: Completed by 3 K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED RETAIL 1214 GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LNIC EDWARD ELLIOT, SR traumatic 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau MERESA ELLIONI (DAUGHTER) 927 MASEFIELD RD. BALTIMORE 21207 MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 05.02.06 OWINGS MILLS MD 21. Signature of Funeral Service License 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE aughn 5151 BAUD. NATE PIKE, BAUTO. MO 21229 23a. Part1. Ent to e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): TE MYD CAR DIAL INFAR LTION. **Examiner** Sequentially list conditions, Examiner 1 any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed DEMENT use as the burial-tran attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 XUnknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 3□ DOA 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Math 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After # or Attanding 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide after within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier malla mo D41410 ad ss of person who completed cause of death (Item 23a) (Type, Print) JOGINDER 1 MEHIA DSPITAL EM MIRTHWEST 31. Date filed (Month, Day, Year) 32, Registrar's Signature State APR 2 6 Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year AFRIL **Physician** EPSTEIN PM 1:51 AARON 22 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4COSPITAL RANDALLSTOWN BALTIMORE NORTH WEST Months Days Hours Min. 8. Date of Birth AWGoth, Days, 1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 76 MD 220-22-8635 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State or items 23a or 28a-f show the Medical Exeminer must be notified at 1 Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21208 7920 SCOTTS LEVEL ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No If Yes, Give 14. Race - American Indian, Black, White, etc. i filed within 72 hours after i I Hygiene. other than "naturel", or ite 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTING 3 ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy important: if item 27 is marked oth any lightly or other traumatic event once. Be **EPSTEIN** TOBY KAPLAN ABRAHAM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3022 NORTH DALE LANE - BOWIE, MD 20716 PHILIP EPSTEIN / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BNAI ISRAEL CEMETERY 04/25/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LOWER GASTROINTESTINAL BLEEDING Physician /Medical Due to (or as a consequence of): Examiner UNKNOWN SOURCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner physicien and s the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an autopsy 2 No 1 Yes After this certification, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours effer death.
To the Funeral Diractor: After the completely filled in by the funeral 27. Manner of Death Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funeral C 167 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54352 APRIL 2006 22 10 MIRCEA TODOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOSPITAL SHOI OLD COURT ROAD RANDALLSTOWN MD 21133 NORTHWEST 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

			-	State of Ma					d Mental Hy	niene	ibic.	
			1 - For State Registrar		,	•	tificate of			Reg. No.	16	13073
	T		1. Decedent's Name (First, Middle, Las	t)	i				2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Elizabeth		rtoi	1			April	23 .	JOOL	9:08 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	-	<i>i</i>	4b. City, Town, o	r Location of De	eath /	4c. Count	y of Death N/A	
_		%	5. Social Security Number 6. So	ice 830	in yrs. la	1051	If Under 1 Year	からで If Under 24 h	Irs. 8. Dark of Birth	K		
	Funeral Director		1	TM 057 F	99	Yrs.	Months Days		in. July 9.	1906	Cour	place (State or Foreign http:// I and
			Usual Residence of Decedent						July 3,	1300		
	arylar	-	10a. State 10b. County			Town or Lo					1	1 ☐ Yes 2 ☐ No
	the Marylar 28a-f ahow notified at	Director	Maryland N/A 10e. Street and Number		Balt	imore	10f. Zip Code			10g. Citizen of	What Cour	ΧΛΛ
	23a or	- Di	830 West 40th Stre	at			2121	1			JSA	my:
	death ms 2: rmms	by Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. \			(Specify Yes or No- ierto Rican, etc.)		ce - Americ	
9	after or ite	Fui	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes ②(X) If Yes, Give	6		r Yes, speciny Cuba I ☐ Yes X X X No	Specify:	ierto Hican, etc.)	Speci	ck, White,	White
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow fre M. of cal Exatrather must be molified at		XXXidowed 4 □ Divorced	Year or Dates:								
45	in 72 "nat	olete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of E	Business/In	dustry
212	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		Homema				Own H	lome
	be filed Ital Hygir d other event.		17. Father's Name (First, Middle, Last)						Name (First, Middle,		me)	
<u>ya</u>	2 should be filed withir and Mental Hygiene. Is marked other than sumatic event. Ine M	To Be	Henry Milton Fost	er				Cath	erine Ada	ms 		
Maryland	2 sho		19a. Informant's Name/Relationship (1	**	nha .				Rural Route Numbe	-		
	1 and 1 Health tem 27		Morton Millard Fos	rer or ne	phew 20b. Pla	ce of Dispo	sition (Name of	1	altimore,	20c. Location		
nor	Pages nent of I int: If its ury or o		XX Burial 2 Cremation 3		cen	netery, crer	natory or other place of Cemete	1	29/06			
Baltimore,			4 □ Donation 5 □ Other (Specify 21 □ gnature of Funeral Provice Lice)		ur et				1itchell-Wie			Maryland
B	permit. Departr Importa any inji		Xennis Deske	n/XPua	Rus				Road Balti			
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused	the death.	Do not ent	er the mode of dyir	ng, such as care	diac or respiratory ar	rest,		Approximate Interval Between
U	Physician		Immediate Cause (Final disease or condition	drevia	selv	which	Carolio	vaser	ear dis	ease	1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):						
	LAUTIMICI	٦	Sequentially list conditions, in any, leading to in more account of the cause. Enter Underlying	b. — Dira to (or as r	s encagnia	ora elle						
প	uted I Insit	Examiner	Cause (Disease or injury	,		recorp.						
Ú	ite be executed lysician and ne burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as a	a conseque	nce of):					==	
68760,	The law requires that the death certificate be executed tite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		, d								
39	leath certifica attending phy i for use as th	Physician/Med	IF FEMALE:					-				
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	eath 3	Ectopic pregnancy	1		1	ate of delive onth	ery Day Year
o.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☑ Ño 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time or dea	ıın 5L	Other (specify) _					
9	res that the igned by be detact	by Ph	Part II. Other significant conditions of	ontributing to death bu	ut not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to th	he cause of death?
Records,	w requires been sign should be								1 D Y	es 2 PNo	3 🗌 Prot	ably 4 Unknown
၀၁	law re	piet							24a. Was		Were auto	psy findings available mpletion of cause of
Ä		Completed							perfo	med? 2 No	death?	2 No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	11					Death (Check only o	ne)		
of	phys this al dii	. To	1 ☐ Yes 2 ☑ No 27. Mann of Death	Hospital: 1 Inpatie		R/Outpatien	- Jergina	4 Nursin	g Home 5 Resid			y)
O	Jing After fune	tion	1 VNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	Injury	Wor	yai rk? Yes 2 □ No	280. Describe i	ow injury occu	1160	
Division	Attending r death. ector: Alter by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At hom	ie, farm, str					ber or Rura	al Route Number,
ă	s after s after s al Direct s s s a s s s s s s s s s s s s s s s	Certification;	4 Homicide	building, etc	c. (Specify)				City or Tow	m, State)		
	To the Hospital or Attenc within 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Ph	ysician: To the best oniner: On the basis of	of my know	edge, death	occurred at the tir	me, date and pl	ace, and due to the c	cause(s) and m	anner as s	tated.
	the hin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner sta	ited.		29c. Licens			29d. Date sign		
	5 7 × 5	-	In Radely The	e Area	47	λ		3657		yrue 2		
	6		30. Name and address of person who	completed cause of d	eath (Item	(Sa) (Two				,		
	9		DELONDIE DING	n PG DD . G	20 W	ILANY	LUT BA	LTI 77.912	D) 77 212	11		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Figistra	ar's Signatu	19 1	Lastes					
	Regist	rar	APR 2 6	ZUUB JORGE	183 1	3. P.	-					

				State of Maryland				Mental	Hygiene	007	10071
		1	For State Registrar	nate of marytain		tificate of L			Reg. No.	UUb	13014
			Decedent's Name (First, Middle, Last)					2. Date of		Year	3. Time of Death
	Physicia /Medic		Baby Boy Fields					Apr	1 12	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
)	Examin		4a. Facility Name (If not institution, give stre	1/200.	1.1	4b. City, Town, or	Location of Dea	ath '	4c.	County of Deat	n
			5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date o	of Birth	9. Birt	hplace (State or Foreign
	Funeral Director		J. Jocial Gooding Hamilton	1 2□F	Yrs.	Months Days	Hours Ma	Apr 2	n, Day, Year) 2006	Mar	yland
	0		Usual Residence of Decedent	100 Cib	/. Town or Loc	ration					10d, Inside City Limits
	arylar ehow	5	10a. State 10b. County		altimo						1√ Yes 2 No
	The M	Director	MD 10e. Street and Number		altino	10f. Zip Code			10g. Cit	izen of What Co	ountry?
3	With With		2227 E. Biddle Stre	et			21213			USA	
	me 2	Funeral		. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of H	ispanic Origin? an, Mexican, Pu	(Specify Yes	or No-	14. Race - Ame Black, Whit	
9	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1	☐ Yes 2💢 No	Specify:			Specify: b1	ack
Š.	within 72 hours after death with the Maryland ana. Than "neturel", or iteme 23a or 28a-f ehow Ta Medical Examinar nout be notified at	d by	3 Widowed 4 Divorced 15. Decedent's Educa	Year or Dates:	16a, Deced	ient's Usual Occup	ation		16b. K	ind of Business	/Industry
7	in 72	plete	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of v	vorking			
212	d with giana	Completed	none non		none				non		1
p	be filed tel Hygir d other event, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, M	iddle, Maider	Surname)	unk
yla	should be nd Mentel marked umatic ev	٦	Kenneth Bell	(Paint)	10h Mailie	ng Address (Street	and Number or	Rural Route f	lumber. City (or Town, State.	Zip Code)
-	d 2 sh th and 7 ie n treun		19a. Informant's Name/Relationship (Type Johns Hopkins Hos			N. Wolfe					
<u>ნ</u>	s 1 and 1 Heelth Item 27 other ti		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. L	ocation - City or	Town, State
Ē	Peges nent of ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☒ Other (Specify)	moval from State	,,	,		_			
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Dapariment of Heelth and Mentlet Hygians. I be partiment of Heelth and Mentlet Hygians. Importent: if item 27 is marked other than 'neturel,' or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinational be notified at once.		21. Signature of Funeral Service Licensee Ronald S. W	ade, Vifrecto	r Si	Name and Addre tate Anat altimore,	ony Boa MD 21	rd 655	W. Ba	ltimore	Street
			23a. Partl. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the deat	th. Do not ent	er the mode of dyi	ng, such as card	diac or respira	tory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ne	Pren	ratu	rity	/		Onset and Death
/	/Medical		resulting in death)	Due to (or as a consec		N					11 -1 -1 -
٠	Examiner	_	Sequentially list conditions, b.	Due to (or as a consec	TO()	De pr	essic	DV1			Molays
	bed Isit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Se DS i		ı					11 days
Ć,	te be executed ysicien and ie burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):	M.,12.					1
760,	ysicle	ca	U d.								
89)	The law requires that the death certificate to the has been signed by the ettending physioned 2 should be detached for use as the books.	Physician/Medi	IF FEMALE:							23d. Date of de	olivon.
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of c	al death 3[☐Ectopic pregnanc	;y			Month	Day Year
<u>o</u> .	at the death by the etter rached for u	ysic	1 Yes 2 No 9 Unknowh	9 Unknown							
<u>α</u>	that hed by deta		Part II. Other significant conditions cont	nbuting to death but not re-	sulting in the u	ınderlying cause gı	ven in Part I.	23€		1	to the cause of death?
rds	w requires been sign should be	ed b	Kespiratory DI	stress Dy	indro	me	,		1 Yes	2月410 3□1	Probably 4 Unknown
of Vital Records,	e law re has bee	Completed by	Persistent Puli	nonary	Hyp	er ter	15/00	24a	. Was an autopsy	24b. Were a prior to death?	autopsy findings available completion of cause of
Ä		S	Intracvania	al Hemor	rhag	6		1 🔀	performed? Yes 2□N		
Vita	ysicien: Th is certificate director, peg	Be	25. Was case referred to medical examiner?	ospital: 1 X Inpatient 2	7.500	O	thor	Death (Check		6 □Other (Sp	nacihi)
	Phys r this aral dii	5	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o				scribe how inj		
ion	nding ath. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		ork? ∃Yes 2⊟No				
Division	or Atterdeg	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st	treet, factory, office			ation (Street or or Town, Sta		Rural Route Number,
_	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical Co	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, dea nation and/or i	th occurred at the nvestigation, in my	time, date and popinion, death	place, and due occurred at the	to the cause e time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	and married states.		29c. Licer	nse number		29d. [Date signed (Mo	nth, Day, Year)
	⊢ 3 ⊢ ŏ		> & Cristeral C	, MD		Doc	600°	10	Ap	vil 13	2006
			30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type	p, Print)	4 0.1	timore	, , ,	7 .212	87
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	natur é 🧈 🔝	wolfe S	i Dall	INNOTE	- 101	N WIN	/3 · 1
	S Regis	tate trar	APR 2 6 2	006 000	200 A						

				State of Ma					_		1 (5 (5 **) 7**
			For State Registrar			Cert	ificate of	Death		Reg. No.	13075
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of Do Month	Day Year	3. Time of Death
	/Medic	al	Helen A.				41. Oh. T	-1	April	21 2006	
1	Examin	er	4a. Facility Name (If not institution, give		1		1205e	r Location of Deat	n	8alti	
	Consul		Franklin Squar 5. Social Security Number 6. S		(In yrs. la		If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth 9. Bi	rthplace (State or Foreign
	Funeral Director			□ M 2 🛛 F	80	Yrs.	Months Days	Hours Min.	Nov. 1	9. Bi av. Year) 2, 1925 MA	ryTand
	P		Usual Residence of Decedent								
	arylar show	_	MD Baltim	ore	Esse	Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h the Maryland r 28a-f show	ecto	10e. Street and Number	OI C	поэс		104 75- 0-4-			too Cities of Miles	
	deeth with the Maryland ms 23s or 28s-f show r must be notified at	Completed by Funeral Director	630 North St	uart Stre	eet		10f. Zip Code 2122	21		10g. Citizen of What C	ountry ?
		ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	. 13. W	as Decedent of It	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	o- 14. Race - Arr Black, Wh	nerican Indian,
98	hours after turs!; or its	F	1 Never Married 2 Married	1 ☐ Yes 2 🛣	10	- 1	□Yes 2. No		, , , , , , , , , , , , , , , , , , , ,	Specify: W	
Ş	hours ture!	b d	3 ☐Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	i	162 Dagada	ant's Heural Occur	nation		16b. Kind of Busines	
	within 72 ene. than "net	Set	(Specify only highest gra	de completed)		(Give k	ind of work done O NOT use retire	pation during most of wo d)	rking		
212	filed within I Hygiene. other than	E	Elementary/Secondary (0-12) 7th	College (1-4or 5	+)	HOme	emaker			own hor	ne
9 5	be filed within tal Hygiene. Id other than svent, it a M	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	e, Maiden Sumame)	
Z ⊥		2	William Tr	avis				·	MAy H	· · · · · · · · · · · · · · · · · · ·	
1, He len Maryland 21215-0036	and and aum		19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •				and Number or Re Stuart		ber, City or Town, State, Balto.	
	1 and 2 Heelth Ism 27	1	Terry Fertig 20a. Method of Disposition	/ son	20b. Pla		tion (Name of		Date	20c. Location - City of	
	ages ant of h it: If Its y or of		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific				of Fai	th 4/2	26/06	Rossvill	
Fert. Baltimore,	permit. Pages Department of I Important: If Its any Injury or of		21. Signature of Funeral Service Licer		1	22.	Name and Addre	ess of Facility 3 ()O MACE	Ave. Bal	to MD
ä	P S E S		1 K. Terr	1 Cons	eli	W (Connell	v Funer	cal Hom	e of Esse	ex 21221
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	nications that caused one cause on each lin	the death.	not enter	r the mode of dyi	ng, such as cardia	c or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Sep		,					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		ence of);					
	Examine:	_	Sequentially list conditions,	b. Due to (or as	T conseque	ance of					
1	ted nsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	540 (6 (5) 43	a conseque	STICE CIE					
Á.	be executed sicien and burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):					
760,	w = m	Ca		d							
89	ntifica ng ph	Med	IF FEMALE:								1
õ	ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal c	death 3□E	Ectopic pregnanc	у		23d. Date of d Month	elivery Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of dea	ath 5⊡	Other (specify) _				
ď.	thet ti	H.	Part II. Other significant conditions of	ontributing to death b	ut not result	ting in the und	derlying cause giv	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ds	luires n sign	D D	MI						1 🗆	Yes 2 No 3 ☐ F	Probably 4 Unknown
2	s bee	olete	CVA						24a. Wa		autopsy findings available
æ	The la	Completed by Physician/Medi							auto perf 1 Yes	ormed? death?	completion of cause of as 2 No
ita	lan: ortifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only		
>	hysic his ce I dire	70	1 ☐ Yes 2 No	Hospital: 1 Inpatie		P/Outpatient	3LI DUA		Home 5□Res	sidence 6 □Other (Sp	ecify)
Division of Vital Records, P.O. Box 68	Jing P	ion:	27. Manner of Death 1 Statural 5 □ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c, Inju Wo	ryat rk? Yes 2 □ No	28d. Describe	how injury occurred	
isic	death death ctor: y the	ficat	Accident investigation 3 Suicide 6 Could not b determined	1	ury - At hon	ne, farm, stre		163 2 10	28f. Location	(Street and Number or I	Rural Route Number,
ē.	al or / s after st Dire	Certification;	4 Homicide determined	building, et	c. (Specify)		, , , , ,		City or To	own, State)	
	To the Hospital or Attending Physician: The law requires thet the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier (Check only one)	niner: On the best and manner sta	examination	rledge, death on and/or inve	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) and manner a , date and place, and di	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1			29c. Licens	se number		29d. Date signed (Mod	
			1 ly ms				DØg	363\$54		April 21, 2	006
	3			completed cause of d	eath (item :	23a) (Type, F	rint)	off City, 1	. ~ ?:		
			31. Date filed (Month, Day, Year)	32 Registr	ar's Signati	meld h	Jay Ellis	OTT CITY, I	~) ZIOL	13	
	Sta Registi		APR 2 6 2	32 Registr	2	A Section	also				

DHMH 17 Rev 1/2001

			1 - State Registrar	State of Ma		epartment of F Certificate of			giene Reg. No.	16 1	3076
В	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	th Day	Year	3. Time of Death
-	/Media	cal	MARTHA W.	FISHER		45 Cit T		April	25,	2006	2:17 a ^M
	Examir	er	4a. Facility Name (If not institution, give 7656 N. Arbory Way			Laure	or Location of Death		4c. County	of Death Se Geor	no!e
	Funeral		Social Security Number 6. S	7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			e (State or Foreign
3	Director			^{□ M 2} X F 8	33 Yr	s. Months Days	Hours Min.	April 8	1923	Maryl	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d.	Inside City Limits
	Mary a-f eh	tor	Maryland Prince G	George's	Laurel						1 XYes 2 No
	th the	lrec	10e. Street and Number			10f. Zip Code		1.	10g. Citizen of W	Vhat Country	?
	ath w	ral	7656 N. Arbory Way			2070			U.S.A		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, it is Medical Examination to after installed an once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ◯ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify.	e - American k, White, etc. Afri Amer	
5-0	natu	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. C	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	oation during most of work	ing	16b. Kind of Bu	isiness/Indus	try
121	within ene. then	mp	Elementary/Secondary (0-12) Grade 12	College (1-4or 5+	-)		d)				
	Hygi other	Be Co	17. Father's Name (First, Middle, Last)			Homemaker	18. Mother's Name	e (First, Middle,	Own Maiden Sumam		
/lan	Menta Menta rrked ric ev	To B	Yellie Warren				Laura Ro	oss			
Maryland	and h		19a. Informant's Name/Relationship (7			Mailing Address (Street					de)
	1 and Health em 27 Iher tr		Judith Ann Baylor	/ daughter	-	321 Nightmi					21044
Baltimore,	Pages iment of hite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery,	isposition (Name of crematory or other place Mem. Park	May	6, 2006			State aryland
Ball	Depart import eny in		21. Signature of Funeral Service Licens		770	22 Name and Addre Donaldsor	ess of Facility n Funeral ott Avenue			land	20707
0	ore sign		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused tone cause on each line	the death. Do no	t enter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Ap	proximate erval Between
	Physician		Immediate Cause (Final disease or condition	a. Advance	d Cardi	omyopathy					years
	/Medical Examiner		resulting in death)		consequence of						7
ca7	35°5	er	Sequentially list conditions, if any, leading to immediate	U	nsuffic:					1	year
$\sqrt{}$	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cardiac	: Arrhytl	nmia				1	year
oʻ	e exectian and and and and and and and and and a	Exe	resulting in death) Last		consequence of						
68760,	ificate be executed g physician and as the burial-transit	edicai	•	d. Congest	ive Hear	rt Failure				4	years
.O. Box	The law requires that the death cert te has been signed by the attending agge 2 should be detached for use	Physician/M	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 214No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 Ectopic pregnancy 5 Other (specify)	у		23d. Date Mor	e of delivery oth Day	y Year
ls, P.	res that signed b	þ	Part II. Other significant conditions co	entributing to death but	t not resulting in t	ne underlying cause giv	ren in Part I.		bacco use contri		
Ö	w require been si should b	eted						1 🗆 Y		3 Probably	/ 4 □Unknown
al Records,	sician: The law certificate has t irector, page 2 s	Completed	OF Management						pmed? d	rior to comple leath?	findings available etion of cause of
i =	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 xo	Hospital: 1 ☐ Inpatien	t 2 ER/Outp	atient 3 DOA Oth	26. Place of Death	n <i>(Check only or</i> me 5 √X Reside		os (Canada)	
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	28b. Tin	ne of 28c. Injur		28d. Describe ho			
Divis	ital or Att is after de ral Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.	(Specify)	, street, factory, office		28f. Location (Si City or Town	n, State)		
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Medical	29a. Certifier XX Certifying Phyone) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination and/	death occurred at the tir or investigation, in my o	me, date and place, opinion, death occurr	and due to the cred at the time, d	ause(s) and mar ate and place, a	nner as stated and due to the	d. cause(s)
	To Teo	Σ	29b. Signature and title of certifier	JAM MA	V	29c. Licens	e number	2	9d. Date signed	(Month, Day	Year)
	Ω			AN MAG		D13	671		April 2	25, 200)6
	X		30. Name and address of person who can be a mane jwala, M.			pe, Print) Park Drive	Laurel,	Marulari	7 20707	7	
ä	Sta		31. Date filed (Month, Day, Year)	32. Registrar		ALT DITAG	naurer,	war Argijo	20707		
	Registr	ar	APR 2 6 2000	Silenian .	A. A.	0460					

DHMH 17 Rev 1/2001

Amend item#7 8 per Handand 5/Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SYLVESTER FRANKLIN 1200 APRIL 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Dave I Under 24 Hrs. 2626 Edgemere Avenue Baltimore Co. 8. Date of Birth (Month, Day, Year) 938 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Director 7.1936Virginia 226-48-6451 Usual Residence of Decedent Feb. with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at Marvland Baltimore Edgemere 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2626 Edgemere Ave. 21219 United States filed within 72 hours after death Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Fabricator Manufacturing permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 Is merked other beny injury or other treumetre 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sylvester Franklin, Sr. Juanita Dykes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Grillo (Friend) 12437 Bel Air Road Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩\$Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 4/25/2006 Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last and use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 □Ectopic pregnancy jo in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) the detached 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe EMPHYSEMA, HEART FAILURE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No or Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this the funeral 27. Magner of Death 28c. injury at Work? After t 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury after death. investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 124 hours a 29a Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai mpletely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62037 APRIL 21 2006, 30. Name an address of person who complete cause of death (Item 23a) (Type, Print) Phni R ayashi, MD CIRCLE BILTIMORE 5505 HOPKINS BAYVIEW 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

APR 2 6 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink Robert Jean Joseph Fournier State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month **Medical Examiner** 1143 hrs April 16, 2006 Robert Jean Joseph Four 4a. Facility Name (if not institution, give street and number) Fournier 4b. City, Town, or Location of Death 4c. County of Death Rt. 301 & Governor Bridge Road **Bowie** Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Months Days Director Hours Min. 1 XM Country) New York 219–80–2848 43 Yrs 08/15/1962 Usual Residence of Decedent ű 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Florida Okaloosa <u>Niceville</u> Director 10e. Street and Number 10g. Citizen of What Country? 1000 Bay Drive, #505 32578 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) X Never Married 2 Married Yes 2 X No Widowed Divorced If Yes, Give Year 1 Yes 2X No specify: Examiner Specify White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Not Self f other than "; 21215-0036 Supporting and Mental Hygiene Dependent 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ient of Health and Mental Hy nnt: If item 27 is marked or or other traumatic event. th Be Raymond Fournier Laurette <u>Briere</u> 19a. Informant's Name/Relationship (Type, Print) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Bay Drive # #505, Niceville, Florida 32578 lery, Date 206 Location - City or Town, State Marc Fournier, Brother crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Important: 1 injury or oth 04/22/2006 Baltimore, Maryland Bayview Crematory Donation Other 22 Name and Address of Facility Heritage Gardens Funeral Home Signature of uneral/Se/vi 21 e Licensee M01113 2201 N. Partin Drive, Niceville, FL 32578 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ethanol intoxication complicating hypertensive Part I Ente **Physician** Approximate Interval Between Onset and /Medical Cardiovascular disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and death certificate be executed Physician/Medical ding physician a e as the burial -X UNPENDED AMENDED item#23a,27,28a-f,perME,g855,5/1/06 TT IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 ✓ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only Be Hospital: 1 Other₄ Inpatient ER/Outpatient 3 DÓA After this Nursing Home 5 Residence 6 Other: Scene ပ 1 V Yes Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ë Natural Pending Yes 2v No Director: Fnd 11:30 AM in by the Fnd 4/16/2006 Certificat 2 Investigation Accident 28f. Location (Street and Number of Rural Route Number, City Rd. or Town State Rt. 301 & Governor Bridge 28e. Place of Injury - At home, farm, street, factory, 6 X Could not be 3 Suicide (Specify) Roadway Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started ca within 2 To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 17, 2006 30 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

32. Prigistrar's Signature

ORIGINAL

State

APR

Registrar

		•	1 - For State Registrar	State of	Maryland		artmen rtificat				lental Hyg	giene Reg No.	5	30	79
			Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ath Day	Year	3. Time	of Death
	Physici /Medio		Mary Louise	Greenhaw							April	20	2006	2:53	P M
	Examir		4a. Facility Name (If not institution, giv		oer)				Location	of Death			ounty of Death		
	7 1		Laurel Regional H					urel		74 Hen			ince Ge		
	Funeral Director		5//-48-46/4	6ex 7. □ M 2 🗓 F	Age (In yrs. la	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day April	y, Year)	34 Was	place (State htry) hingt	on, D
	, A		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside (City Limits
	-f ehc	ţ	MD How	ard	I	Laurel								1 🗌 Ye	s 2⊠No
4	7288	lrec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?	
	23a o	alD	19 Center Street					207					USA		
950	s 1 and 2 should be lied within 72 hours after dean with the maryland of Health and Mental Hygiene. After the marked other than "natural", or thems 23a or 28a-f ehow other traumatic event, the Medical Erent are must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Poivorced	12. Was Deced Armed Force 1 Tyes 2 If Yes, Give Year or Dat	es? MNo		Was Deced If Yes, spec 1 ☐ Yes	**	ispanic Or In, Mexical Specify:		ecify Yes or No- Rican, etc.)		. Race - Americ Black, White, pecify: Wh		
5	n 'antura	Completed	15. Decedent's E (Specify only highest gr.		tor 5 t)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT u	al Occupa rk done d se retired	ation during mos	st of work	ing	16b. Kind	of Business/In	dustry	
717	the state	E	Elementary/Secondary (0-12) 8th	Ø	+01 3+)	Home	emaker	-					n Home		
	al Hyg	Bec	17. Father's Name (First, Middle, Last								e (First, Middle,		umame)		
<u>ק</u>	snould be nd Mental marked o	2	Jesse James Hi	.11							e R. Bi				
=	and to man		19a. Informant's Name/Relationship								al Route Numbe			Code)	
ນົ	1 and 1ealth 1m 27 1m 27 ther tr		Margaret Houck/Si	ster	20b. P	A second second					rel, MD		∠ 3 ation - City or To	own, Slate	
5	permit. Pages 1 an Department of Heali Important: If Item 2 any njury or other ance.		1 XBurial 2 ☐ Cremation 3 €		iate	lace of Dispo emetery, cre				1/21	/2006		_		
	rtmer rtant njury		4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice		FT	. Linc	2. Name ar	d Addre	ss of Facili	4/24 ity D	/2006 onaldso:		twood, eral Ho		.A.
0	Dep Imp any		CANICO &		₩01103						e, Laur			-	
	× 14		23a. Part1 Ener the disease, or conshoot, or eart failure. List only		used the death ch line.		ter the mod	le of dyin	ig, such as	s cardiac	or respiratory ai	rrest,		Approxim Inferval B Onset and	etween d Death
	hysician /Medical		disease or condition resulting in death)	_ a	r as a consequ										
2-	Examiner			F	Respira		ailuı	ce						1 d	ay
7		ner	Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury	· ·	Fas a ourisay										
V	rate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Cardiac		st							ı n	our
,00,	be exe ician a burial-		lesding in death) cast	*	rasa consequ Atheros		ic Va	scu	lar D	isea	se			5 v	ears
50	cate b	dical		_ d		010100									
ň	res that the death certificate signed by the attending phys I be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		th 2∏Fetal nt at time of d	Ideath 3	⊒Ectopic p ⊒ Other (s _i		′			23	d. Date of deliv Month	ery Day	Year
ř.	that the the the the the the the the the th		Part II. Other significant conditions	contributing to dea	ath but not resi	ulting in the u	underlying	ause giv	en in Part	l.	23e. Did t	tobacco use	e contribute to	the cause o	f death?
ords	requires that een signed b hould be deta	d by									10	Yes 2	No 3□Pro	bably 4 [Hinknown
O		Completed									24a. Was		24b. Were aut	opsy finding	s available
Ž Č	The Is	E									perfo	ormed?	death? 1 ☐ Yes	2∭ No	
VITal		BeC	25. Was case referred to medical examiner?						26. Plac	e of Dea	th (Check only o	опе)			
01 <	Physic this ce al dire	은	1 ☐ Yes 2💢 No			ER/Outpatie			4 🗀 🛚 🗸	lursing H	ome 5 Resi			fy)	
	ding P h. After I funera	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	- 1	n, Day Year)	28b. Time o Injury	M	28c. Injur Wor	yat rk? Yes 2.[3No	28d. Describe	now injury	occurred		
<u> </u>	or Attending Physician: ifter death. Director: After this certific in by the funeral director,	cat	2 Accident investigation 3 Suicide 6 Could not	be 390 Place	of Injury - At he	ome, farm, s			103 2 [28f. Location (Street and	Number or Rui	al Route N	umber,
Division	lor A after Direct	Certification:	4 Homicide determine	buildin	g, etc. (Specif	y)		,,			City or To	wn, State)			
	To the Hospital or Attern within 24 hours after deati To the Funeral Director: completely filled in by the	Medical C	29a. Certifier Certifying F (Check only one)	hysicien: To the miner: On the ba and mann	sis of examina	wledge, dea tion and/or i	th occurred	at the til	me, date a opinion, de	and place eath occu	, and due to the rred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause	9(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifies				29	c. Licens	se number			29d. Date	signed (Month	Day, Year)
			& Thank	1	MD		D	DO	055	10	9	4/2	22/06	•	
	1		30. Name and address of person who		of death (Iten	n 23a) (Type	, Print)	Б -	_			1	20071	c	
			Balnath Bhanda			 	HITT	Road	Oxo	on H:	ill, Mar	cyrano	3 2074	5	
100	S	tate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	alule *									

DHMH 17 Rev 1/2001

Registrar

APR 2 6 2006 Second M. Aparles

ORIGINAL

06-02600 Josephine C. Gollick

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		Registrar		OCI	tificate of i				Reg. No. 💪 🔰	UU	100
Physici		1. Decedent's Name (First, Mid	dle,Last)					2. Date of De		3. Time of Death	٦
ledical Exami		Josephino	C. Gollick					Month April 17,	Day Yea 2006	o509 hrs	
		4a Facility Name (if not institut	ion, give street and number)		o. City, Town, or L	ocation of Death	_	4c. County of	of Death	
		Interstate 81 /Mile m				Hagerstown			Washing		
		Social Security Number		e (In yrs. la	et hirthday'	If Under 1 Year	If Heder 0412.	9 Date of F			
Funeral		i		-	or pirmuay)	Months Days	If Under 24Hrs Hours Min.	_	,	Birthplace (State or Foreign	
Director		249-98-2483	1 M 2X F	52	Yrs	l buys		11/09	9/1953	Country) Franc	e
	ľ	Usual Residence of Decedent									
any	Ī	10a State 10b. County	/	10c. City,	Town or Locatio	n				10d. Inside City	Limits
Maryłand 28a-f show any d at once.	إ	PA Cur	mberland	NT-	wville					1 Yes 2	y No
yłan I-f sł	Director	10e. Street and Number	INCT TOTAL	I NE		10f, Zip Code			10g. Citizen of Wh		Λ
Mar r 28;	ē	100. Otiest and Number				Tot. Zip odde			iog. Gilizell of VVI	at country?	
ith the Maryland 23a or 28a-f sho notified at once.		173 Country V	iew Estates			17241			United	States	
ms 2.	Funeral	11. Marital Status	12. Was Decedent			Decedent of Hisp			lo- 14. Race	- American Indian, Black	,
r death or iter	Ĕ	1 Never Married 2	Wiai Heu	X No	I If Yes	s, specify Cuban,	iviexican, Puerto	rican, etc.)	White	e, etc.	
fter (3 Widowed 4 X D	ivorced If Yes, Give Year	¥₹	1 1	Yes 2 X No	specify:		Specify:	White	
5036 within 72 hours afte iene rer than "natural", Medical Examiner	ğ	15. Decedent's Education (Sp	or Dates:	npleted)	16a. Decedent's	s Usual Occupation	on (Give kind of v		16b. Kind of Bu		
2 hou mai	ompleted	Elementary/Secondary (0-12	College (1-4 or	5+)	during mos	st of working life. I	DO NOT use reti	red)		-	
36 lin 7 han dical	립			<i>'</i>	T.T	hour- 7		E	TTC	ozene	
with ber 1	틍	12 17. Father's Name (First, Middl	e last)		ware	house Ar			, Maiden Surname)	ernment	
filed filed at the	Ö		,						, maiden oumaine)		
21215-0036 uld be filed within 7 Mental Hygiene marked other than	മ	Peter Gollich	<u>C</u>		1401-11-11	• • • • •	Kathe	rine	Eder		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relation	ISNIP (Type, Print)						umber, City or Town		
MD id 2 sho Ith and in 27 is	Ł	Christina D. I	ittle, Daugh	ter	1416 B	radley D	rive. #	н312. (arlisle.	PA 17013 City or Town, State	
e, an Heal		20a. Method of Disposition	,	20b. P	lace of Dispositi rematory or other	ion (Name of ceme	etery,	Date	20c. Location -	City or Town, State	~~
ages nt of othe		23	on 3 Removal from St	HO]	linger	FH & Cro	matory	04/21/2	2006 Penn	Holly Sprin	ys
Baltimore, permit Pages I ar Department of Hee Important: If ite	ŀ	4 Donation 5 Other 3	Specify:	1.101		me and Address	of Facilitys-		-100 bein	syrvania	T
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical		11111 WILL	171.	MO111						& Cremetory,	ınc.
	_	230 Bort 5-10-1	11/ 17	M0111						s, PA 17065	
Physician (Modical		23a. Part I. Enter the disease, difficulties. List only one cause		ine death.	Do not enter the	mode of dying, s	iucn as cardiac o	r respiratory a	rrest, snock, or hea	Approximate In Between Onse	
/Medical =xaminer		Immediate Cause (Final diseas		3						Death	
xanınıeı		or condition resulting in death)		equence of):						
The same of the sa		Sequentially list conditions,	b								
	ner	if any, leading to immediate	Due to (or as a cons	equence of):						
	Ē	cause. Enter Underlying Caus (Disease or injury that initiated	C								
si sq	Examin	events resulting in death) Last		equence of):						
ecute and tran	e		d								
rtificate be executed ing physician and as the burial - transi	ledical	UNPENDED	AMENDED								
68760, ertificate be ding physici	Σe	IF FEMALE:	23c. If yes, outco	me of pregn	ancy				23d Date of	delivery	1
687 ertific	7	23b. Was decedent pregnant in past 12 months?	the 1 Live birth		2 Feta	al death 3	Ectopic pregna	ncy	Month		ar
Box 687 e death certifi the attending	:5				-			•	MONTH	Day Yea	
Fo a deg	10		4 Pregnant a	t time of dea	ath =	er (Specify)			I	Day Yea	
ا ق ا	hys	1 Yes 2 No 9 🗸 U	4 Pregnant at		ath 5 Othe	er (Specify)				,	
O. Enat the d	y Physicia		4 Pregnant at		ath 5 Othe	er (Specify)	ven in Part I.			Day Yea	th?
P.O. Eres that the osigned by the detached	<u>a</u>	1 Yes 2 No 9 🗸 U	4 Pregnant at		ath 5 Othe	er (Specify)	ven in Part I.	23e Did	tobacco use contri	,	
ds, P.O. Box 6 requires that the death cert over signed by the attendit ould be detached for use a	<u>a</u>	1 Yes 2 No 9 🗸 U	4 Pregnant at		ath 5 Othe	er (Specify)	ven in Part I.	23e Did 1 Y 24a Wa	tobacco use contril es 2 No 3 s an 24b. V	bute to the cause of deat Probably 4 Unkr	nown ailable
cords, P.O. E law requires that the chas been signed by the 2 should be detached	<u>a</u>	1 Yes 2 No 9 🗸 U	4 Pregnant at		ath 5 Othe	er (Specify)	ven in Part I.	23e Did 1 Y 24a Wa	tobacco use contril es 2 No 3 s an 24b. V	bute to the cause of deat Probably 4 Unkr	nown ailable
Records, P.O. E The law requires that the c cate has been signed by th page 2 should be detached	<u>a</u>	1 Yes 2 No 9 🗸 U	4 Pregnant at		ath 5 Othe	er (Specify)	ven in Part I.	23e Did 1 Y 24a Wa autr	tobacco use contril es 2 M No 3 s an 24b. V ppsy p formed?	bute to the cause of deat Probably 4 Unkr Vere autopsy findings avairior to completion of cause eath?	nown ailable
al Records, P.O. E an: The law requires that the c ertificate has been signed by th stor, page 2 should be detached	Completed by	1 Yes 2 No 9 ✔ U Part II. Other significant cond 25. Was case referred to medic	4 Pregnant at guident and guident at guident		ath 5 Othe	er (Specify) derlying cause give	of Death (Check	23e Did 1 Y 24a Wa autr peri 1 Yes	tobacco use contril es 2 M No 3 s an 24b. V ppsy p formed?	bute to the cause of deat Probably 4 Unkr Vere autopsy findings avairor to completion of causeath?	ailable se of
Vital Records, P.O. E ssician: The law requires that the chis certificate has been signed by the director, page 2 should be detached	Be Completed by	1 Yes 2 No 9 ✔ U Part II. Other significant cond 25. Was case referred to medic examiner?	4 Pregnant at 9 Unknown litions contributing to deat	h but not re	ath 5 Othe	er (Specify) derlying cause give	of Death (Check	23e Did 1 Y 24a Wa autr peri 1 Yes	tobacco use contril es 2 M No 3 s an 24b. V ppsy p formed?	bute to the cause of deat Probably 4 Unkr Vere autopsy findings avarior to completion of causeath? Yes 2 1	ailable se of
of Vital Records, P.O. E g Physician: The law requires that the content of the this certificate has been signed by the reral director, page 2 should be detached	: To Be Completed by	1 Yes 2 No 9 ✔ U Part II. Other significant cond 25. Was case referred to medic	4 Pregnant a 9 Unknown Southing to deat Hospital: 1 Inpation	ent 2	ath 5 Other	26.Place of 3 DOA	of Death (Check	23e Did 1 Y 24a Wa auto pert 1 Yes only one) 1g Home 5	tobacco use contrilles 2 No 3 san 24b V ppsy oformed? 2 No 1	bute to the cause of deat Probably 4 Unknown United Section 1 of Cause at 1 of Cause a	ailable se of
on of Vital Records, P.O. Ending Physician: The law requires that the oth. H. After this certificate has been signed by the fineral director, page 2 should be detached	: To Be Completed by	Part II. Other significant cond 25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death	4 Pregnant at 9 Unknown litions contributing to deat Hospital: 1 Inpatie	ent 2	ath 5 Other	26. Place of 3 DOA Cury 28c. Injury	of Death (Check other'4 Nursin at Work?	23e Did 1 Y 24a Wa aute 1 Yes only one) 19 Home 5 28d. Describe	tobacco use contrilles 2 No 3 san 24b. V ppsy formed? 2 No 1	bute to the cause of deat Probably 4 Unkr Vere autopsy findings avarior to completion of causeath? Yes 2 N Other: Scene	ailable se of
Sion of Vital Records, P.O. E Attending Physician: The law requires that the or cleath. ector: After this certificate has been signed by th by the funeral director, page 2 should be detached	: To Be Completed by	Part II. Other significant cond 25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Per	4 Pregnant at 9 Unknown 9 Unknown litions contributing to deat Hospital: 1 Inpation 17, 2006	ent 2 ury	sulting in the un ER/Outpatient 28b. Time of Inj 0501 hrs	26.Place of 3 DOA Ury 28c. Injury	of Death (Check other'4 Nursing at Work? es 2 No	23e Did 1 Y 24a Wa aute 1 Yes only one) 19 Home 5 28d. Describe Driver of vi	tobacco use contri es 2 No 3 s an 24b. V ppsy formed? 2 No 1 Residence 6 e how injury occurre an which struc	bute to the cause of deat Probably 4 Unkr Vere autopsy findings averior to completion of causeath? Yes 2 N Other: Scene ed k a tree	ailable se of
hivision of Vital Records, P.O. E for Attending Physician: The law requires that the carter death. Director: After this certificate has been signed by the fineral director, page 2 should be detached.	: To Be Completed by	Part II. Other significant cond 25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pei 2 ✓ Accident Inv 3 Suicide 6 Co	4 Pregnant at 9 Unknown 9 Unknown 19 Unknown 19 Unknown 20 Unknown	ent 2 ury /ear)	existing in the unsulting in the unsulti	26. Place of 3 DOA Cury 28c. Injury	of Death (Check Other'4 Nursin at Work? es 2 No ilding, etc.	23e Did 1 Y 24a Wa aut 1 Yes only one) 28d Describe Driver of vi 28f. Location or Town,	tobacco use contribes 2 No 3 s an 24b. V popsy ormed? 2 No 1 Residence 6 Per how injury occurre an which struc (Street and Number State)	bute to the cause of deat Probably 4 Unknown Vere autopsy findings avairor to completion of cause eath? Yes 2 N Other: Scene ed k a tree	nown ailable se of No r, City
Division of Vital Records, P.O. Espital or Attending Physician: The law requires that the cours after death. neral Director: After this certificate has been signed by th filled in by the funeral director, page 2 should be detached	: To Be Completed by	25. Was case referred to medic examiner? 1 Yes 2 No 9 V U 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Accident Inv 3 Suicide 6 Co	4 Pregnant at 9 Unknown 9 Unknown 19 Unknown 19 Unknown 20 Unknown 28a. Date of Injuncting and Injuncting 28a. Date of Injuncting 28a. Date of Injuncting 28a. Place of Inj	ent 2 ury /ear)	existing in the unsulting in the unsulti	26.Place of 3 DOA Ury 28c. Injury	of Death (Check Other'4 Nursin at Work? es 2 No ilding, etc.	23e Did 1 Y 24a Wa aut 1 Yes only one) 28d Describe Driver of vi 28f. Location or Town,	tobacco use contribes 2 No 3 s an 24b. V popsy ormed? 2 No 1 Residence 6 Per how injury occurre an which struc (Street and Number State)	bute to the cause of deat Probably 4 Unkr Vere autopsy findings averior to completion of causeath? Yes 2 N Other: Scene ed k a tree	nown ailable se of No r, City
Division of Vital Records, P.O. E. Hospital or Attending Physician: The law requires that the c. 24 hours after death. Funeral Director: After this certificate has been signed by the tell pirector: After this certificate has been signed by the tell pirector.	Certification: To Be Completed by	Part II. Other significant cond 25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 ✓ Accident Inv 3 Suicide 6 Co 4 Homicide 29a Certifier Office korby 1 Certifying	Hospital: 1 Inpatie al Hospital: 1 Inpatie 28a. Date of Inj. Apr 17, 2006 restigation and be termined (Specify) Int. Physician: To the best of means and the second contributing to death and the second contributing to death and the second contributing to death and the second contribution and the second co	ent 2 ury /ear) njury - At ho	ER/Outpatient 28b. Time of Inj 0501 hrs me, farm, street express e, death occurre	26.Place of 3 DOA Cury 28c. Injury 1 Ye, factory, office bu	of Death (Check Other'4 Nursin of at Work? es 2 No illding, etc.	23e Did 1 Y 24a Wa aut per 1 Yes only one) 28d Describe Driver of vi 28f. Location or Town, Interstate due to the cai	tobacco use contri es 2 No 3 s an 24b. V popsy dormed? 2 No 1 Residence 6 a how injury occurre an which struc (Street and Numbe State) 81 at Mile Marl use(s) and manner	bute to the cause of deat Probably 4 Unknown Vere autopsy findings avairor to completion of cause eath? Yes 2 N Other: Scene ed k a tree ever or Rural Route Number over 11, Hagerstown as started.	nown ailable se of No r, City
Division of Vital Records, P.O. E thin 24 hours after death. • the Funeral Director: After this certificate has been signed by the mappletely filled in by the funeral director:	Certification: To Be Completed by	Part II. Other significant cond 25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 ✓ Accident Inv 3 Suicide 6 Co 4 Homicide 29a Certifier Office korby 1 Certifying	Hospital: 1 Inpation of the In	ent 2 ury /ear) njury - At ho	ER/Outpatient 28b. Time of Inj 0501 hrs me, farm, street express e, death occurre	26.Place of 3 DOA Cury 28c. Injury 1 Ye, factory, office bu	of Death (Check Other'4 Nursin of at Work? es 2 No illding, etc.	23e Did 1 Y 24a Wa aut per 1 Yes only one) 28d Describe Driver of vi 28f. Location or Town, Interstate due to the cai	tobacco use contri es 2 No 3 s an 24b. V popsy dormed? 2 No 1 Residence 6 a how injury occurre an which struc (Street and Numbe State) 81 at Mile Marl use(s) and manner	bute to the cause of deat Probably 4 Unknown Vere autopsy findings avairor to completion of cause eath? Yes 2 N Other: Scene ed k a tree ever or Rural Route Number over 11, Hagerstown as started.	nown ailable se of No r, City
Sion of Vital Records, P.O. Attending Physician: The law requires that th death. ector: After this certificate has been signed by by the funeral director, page 2 should be deach	edical Certification: To Be Completed by	Part II. Other significant cond 25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 ✓ Accident Inv 3 Suicide 6 Co 4 Homicide 29a Certifier Office korby 1 Certifying	Hospital: 1 Inpation of the physician: To the best of manuary stated.	ent 2 ury /ear) njury - At ho	ER/Outpatient 28b. Time of Inj 0501 hrs me, farm, street express e, death occurre	26.Place of 3 DOA Cury 28c. Injury 1 Ye, factory, office bu	of Death (Check other4 Nursin vat Work? es 2 No iliding, etc. e and place, and death occurred a	23e Did 1 Y 24a Wa aut per 1 Yes only one) 28d Describe Driver of vi 28f. Location or Town, Interstate due to the cai	tobacco use contril es 2 No 3 s an 24b. V ppsy pormed? 2 No 1 Residence 6 e how injury occurre an which struc (Street and Numbe State) 81 at Mile Mari use(s) and manner e and place, and di	bute to the cause of deat Probably 4 Unknown Vere autopsy findings avairor to completion of cause eath? Yes 2 N Other: Scene ed k a tree ever or Rural Route Number over 11, Hagerstown as started.	nown ailable se of No r, City
Division of Vital Records, P.O. E To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: To Be Completed by	25. Was case referred to medice examiner? 1 Yes 2 No 9 U 25. Was case referred to medice examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pet Inv 3 Suicide 6 Co 4 Homicide 29a Certifier 1 Certifying one) 2 Medical Ex	Hospital: 1 Inpation of the physician: To the best of manuary stated.	ent 2 ury /ear) njury - At ho	ER/Outpatient 28b. Time of Inj 0501 hrs me, farm, street express e, death occurre	26.Place of 3 DOA Cury 28c. Injury 1 Yes, factory, office but 29c. License	of Death (Check)ther'4 Nursin at Work? es 2 No iliding, etc. e and place, and death occurred a	23e Did 1 Y 24a Wa aut per 1 Yes only one) 28d Describe Driver of vi 28f. Location or Town, Interstate due to the cai	tobacco use contri es 2 No 3 s an 24b. V popsy formed? 2 No 1 Residence 6 Period of the control	bute to the cause of deat Probably 4 Unknown of Completion of Cause eath? Other: Scene and k a tree For or Rural Route Number or Rural Route Number as started. Let to the cause(s)	nown ailable se of No r, City
	Certification: To Be Completed by	Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per Invariant Suicide 6 Co det 29a Certifier 1 Certifying one) 2 Medical Ex 29b. Signature end title of certifier of certif	Hospital: 1 Inpation of the basis of examiner: On the basis of examiners and manner stated.	ent 2 ury rear) njury - At ho erstate/E ny knowledg	ER/Outpatient 28b. Time of Inj 0501 hrs me, farm, street Express ie, death occurre	26.Place of 3 DOA Cury 28c. Injury 1 Ye, factory, office bued at the time, date on, in my opinion,	of Death (Check)ther'4 Nursin at Work? es 2 No iliding, etc. e and place, and death occurred a	23e Did 1 Y 24a Wa aut per 1 Yes only one) 28d Describe Driver of vi 28f. Location or Town, Interstate due to the cai	tobacco use contril es 2 No 3 s an 24b. V ppsy pormed? 2 No 1 Residence 6 e how injury occurre an which struc (Street and Numbe State) 81 at Mile Mari use(s) and manner e and place, and di	bute to the cause of deat Probably 4 Unknown of Completion of Cause eath? Other: Scene and k a tree For or Rural Route Number or Rural Route Number as started. Let to the cause(s)	nown ailable se of No r, City
Division of Vital Records, P.O. E To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: To Be Completed by	25. Was case referred to medic examiner? 1 Yes 2 No 9 U 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per Invariant	Hospital: 1 Inpation of the properties of the pr	ent 2 ury rear) njury - At ho erstate/E ny knowledg imination ar	ER/Outpatient 28b. Time of Inj 0501 hrs me, farm, street Express ie, death occurre id/or investigation	26. Place of 3 DOA Courty 1 Yes, factory, office but 29c. License O.C.M	of Death (Check other'4 Nursin of at Work? es 2 No ilding, etc. e and place, and death occurred a number 1.E.	23e Did 1 Y 24a Wa aut yer 1 Yes only one) 1 28d Describe Driver of Vi 28f. Location or Town, Interstate due to the cal at the time, dat	tobacco use contri es 2 No 3 s an 24b. V popsy formed? 2 No 1 Residence 6 Period of the control	bute to the cause of deat Probably 4 Unknown of Completion of Cause eath? Other: Scene and k a tree For or Rural Route Number or Rural Route Number as started. Let to the cause(s)	nown ailable se of No r, City
	Medical Certification: To Be Completed by	25. Was case referred to medic examiner? 1 Yes 2 No 9 V U Part II. Other significant cond 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pei 2 Accident Inv 3 Suicide 6 Co 4 Homicide 29a Certifier 1 Certifying one) 2 Medical Ex 29b. Signature and vitte of certifier 30. Name and address of parson Mary G. Ripple MD.	Hospital: 1 Inpation of the last of the la	ent 2 ury rear) njury - At ho erstate/E ny knowledg imination ar	ER/Outpatient 28b. Time of Inj 0501 hrs me, farm, street Express ie, death occurre id/or investigation	26.Place of 3 DOA Cury 28c. Injury 1 Yes, factory, office but 29c. License	of Death (Check other'4 Nursin of at Work? es 2 No ilding, etc. e and place, and death occurred a number 1.E.	23e Did 1 Y 24a Wa aut yer 1 Yes only one) 1 28d Describe Driver of Vi 28f. Location or Town, Interstate due to the cal at the time, dat	tobacco use contri es 2 No 3 s an 24b. V popsy formed? 2 No 1 Residence 6 Period of the control	bute to the cause of deat Probably 4 Unknown of Completion of Cause eath? Other: Scene and k a tree For or Rural Route Number or Rural Route Number as started. Let to the cause(s)	nown ailable se of No r, City
• 1s	Medical Certification: To Be Completed by	25. Was case referred to medic examiner? 1 Yes 2 No 9 U 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per Invariant	Hospital: 1 Inpation of the last of the la	ent 2 ury rear) njury - At ho erstate/E ny knowledg imination ar	ER/Outpatient 28b. Time of Inj 0501 hrs me, farm, street express le, death occurre ad/or investigation	26. Place of 3 DOA Courty 1 Yes, factory, office but 29c. License O.C.M	of Death (Check other'4 Nursin of at Work? es 2 No ilding, etc. e and place, and death occurred a number 1.E.	23e Did 1 Y 24a Wa aut yer 1 Yes only one) 1 28d Describe Driver of Vi 28f. Location or Town, Interstate due to the cal at the time, dat	tobacco use contri es 2 No 3 s an 24b. V popsy formed? 2 No 1 Residence 6 Period of the control	bute to the cause of deat Probably 4 Unknown of Completion of Cause eath? Other: Scene and k a tree For or Rural Route Number or Rural Route Number as started. Let to the cause(s)	nown ailable se of No r, City

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#16a, 21a, perFH, 854, 4/26/06 TI State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death APRIL 23, 2006 **GOLDMAN** GAIL 6:45 A 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 438 CRANES ROOST COURT ANNAPOLIS ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Mark | Days | Hours | Min. | MAR. 31, 1945 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 ☐ M 2 ☑ F 61 Yrs 212-44-8805 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔯 No ANNE ARUNDEL ANNAPOLIS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 438 CRANES ROOST COURT 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) MATHMATICIAN Mathematician NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SANDLER PEARL **KAUFER** PAUL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 438 CRANES ROOST COURT - ANNAPOLIS, MD 21401 WILLIAM GOLDMAN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Borial 2 Cremation 3 Removal from State HILLTOP SERVICE CORP | 04/26/2006 4 ☐ Donation 5 ☐ Other (Specify) TOWSON, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Beath (ARCINDMA YEAK Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 X No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home Statesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Physician /Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Box 68760, ettending for use as P.0. Division of Vital Records, death. Director within 24 hours after d To the Funeral Direct completely filled in by

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or itema 23e or 28e-f ahow the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Menial Hygiene.
Important: If Itam 27 is marked other then "natural", or iten any injury or other traumatic avant, the Moulcal Examinat once.

Baltimore, Maryland 21215-0036

Funeral Director

þ

Be Completed

ဂ

Physician/Medical Examiner

þ

Be Completed

Medical Certification: To

with the Marylend

State Registrar

31. Date filed (Month, Day, Year)

APR 2 6

29b. Signature and title of certifier

(Check only one)

30 Name and address

32 Registrar's Signature

		•	1 → For State Registrar	State of Marylan			nt of He te of D		d Mer		ene g. No.)6	130	82
	Physici		1. Decedent's Name (First, Middle, Last) Frederic All	ert Grier	III					Date of Deat Month pril 2	1, Day 200)6 ^{Year}	3. Time of 7:35	f Death AM
4	/Medio Examin		4a. Facility Name (If not institution, give 1703 Gruenther Av			,	Town, or	Location of De	ath		4c. Count	ty of Death	ry	
	Funeral Director		5. Social Security Number 6. Security 1214-22-9217	7. Age (In yrs.	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 H Hours Mi	in.	Date of Birth Month, Day, tober 3		9. Birthe Cour Mary		or Foreign
	Maryland a-f show	stor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer		y, Town or Loc							1	l0d. Inside C	ity Limits
	with the	il Director	10e. Street and Number 1703 Gruenther Ave	enue			0851				og. Citizen of Inited		•	
350	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-1 show amy injury or other traumatic event, Ite Maryland Examiner must be nullified at once.	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 N Yes 2 No 194 If Yes, Give Year or Dates: 196	6- "	Vas Dece i Yes, spe	ecify Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify erto Rica	Yes or No- an, etc.)	Bi	ace - Amendack, White, ify: Whi	etc.	
Maryland 21215-0036	within 72 hou ene. than "nature ne Moussal E	Completed	15. Decedent's Eld (Specify only highest grad		16a. Deced (Give life. L	kind of wi	ork done d ise retired)	uring most of v	working		Insura			У
and 2	ld be filed ental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Calvin Turner	Grier				18. Mother's N		rst, Middle, M Wingat		ате)	-	
Mary	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (T) Emma Virginia Grier,			-		nd Number or Avenue			-			51
Baltimore,	Pages 1 a lent of Hea nt: if item ry or otha		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lomoval from State	Place of Dispo- cemetery, crem gomery	natory or	other place	Ap.	Date ril 2006	23.	Bethes			nd
Balt	permit. Departm importa eny inju		21. Signature of Funeral Service Licens	M00092	Ro Ro	Name a ockvi ockvi	nd Addres 11e, 11e,	s of Facility R Inc. 3 Maryla	8ber	t A. H est Mc 0850-2	Cumphre ontgome 1805	ey Fur ery Av	neral Venue	Home
26 m	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line. Respirator	h. Do not ente	er the mo							Approxima Interval Be Onset and	tween
##	/Medical Examiner		resutting in death)	Due to (or as a consec Pulmonary		is								
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	dence of):									
8760,	cate be executed only sicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consect.	uence of):									1
P.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	il death 3	Ectopic p Other (s	pregnancy pecify)					Date of deliving	•	Year
	quires that t n signed by uld be deta	d by Ph	Part II. Dther significant conditions co Ischemic Cardiom		sulting in the ur	nderlying	cause give	on in Part I.			oacco use co es 2 🗆 No		he cause of	
Division of Vital Records,		Completed							-	24a. Was a autops perform	v	b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings impletion of a	available cause of
Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	1500		Othe	26. Place of D			•			
on of	ding After	tion: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	4 14012111		5 K Reside			ny)	
Divis	5 £ £ €	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, facto	ry, office		28f.	Location (St City or Town		nber or Rur	al Route Nun	n <i>ber</i> ,
	To the Hospital within 24 hours a To the Funerel Completely filled	edicai C		sician: To the best of my kni ner: On the basis of examination and manner stated.										s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	- MO		29	D362				9d. Date sign April			
11	1+1	3	30. Name and address of person who Steven T. Kariya,	mpleted cause of death (Ite	Georgia	a Ave	enue	#515, W	√heat	ton, M	arylan	d 209	02-195	56
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2. 6. 200	7. Registrar's Sign	ature	de								

Please Type or Print in Black Indelible Ink

	Please	Type or F	rint in t	Slack Inc	aenbie ini	
ate of	f Marylan	d / Denari	ment of	Health a	and Mental	Hygier

۵.	2	0	06)	3	8	
٥.							

Handiboe, Stephen	
	1- For State Registrar
Physician/	Decedent
Medical Examiner	Ste
	4a. Facility I
	Laure
Funeral Director	5. Social Se
	Usual Resid

Physiciar Il Examin	_	Registrar				Death					Reg.	No.	A ()	
		Decedent's Name (First, Middle,	Last)						2.	Date of I	Death			3. Time of Death
	_	Stephen Handi	iboe							Month April 1		ay Ye 16	ar	0:30
	1	4a. Facility Name (if not institution, Laurel Regional Hospit	give street and number	er)	41	o. City, Town Laurel	, or Lo	cation of				4c. County	of Death George'	s
				Age (In yrs last bir	thday)	If Under 1	Voar	If I Inder	24Hre	8 Date o	f Rirth /		_	
Funeral Director		5. Social Security Number unk^{ϵ}	1XM 2 F	51	Yrs.	Months I	Days	Hours	IVIII I.	Dec			Cou	iplace (State or Fo ntry)
		Usual Residence of Decedent												
any		10a. State 10b County	unl	10c. City, Town	or Locatio	n								10d. Inside City L
how Ce.	_	MD		Lewi	sdale	2								1 Yes 2 X
rrylar sa-fs	Director	10e. Street and Number		Lews		10f. Zip Cod	le			unk	10g.	Citizen of W	/hat Count	ry?
e Ma or 28 ied a	ē.	2409 Amhurst I	Pood							ulik		US		
ith the Maryland 23a or 28a-f show notified at once.														
filed within 72 hours after death with the Maryland I Hygiene ed other than "natural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once	Funeral	11 Marital Status UI 1 Never Married 2 Mar	nk 12. Was Decede Armed Force 1 Yes			Decedent of s, specify Cu							e - Americ te, etc.	an Indian, Black,
fter d		3 Widowed 4 Divo	rced If Yes, Give Year		1 1	Yes 2 X	No s	specify:				Specify:	whit	e
hin 72 hours after e than "natural", edical Examiner	d by	15. Decedent's Education (Speci	or Dates: fy only highest grade c	ompleted) 16a.	Decedent's	s Usual Occi	upation	(Give kir	nd of wor	k done	nk 16	b. Kind of B		
2 ho	Completed	Elementary/Secondary (0-12)	College (1-4 c	durin	g	orking life. D								
hin 7 e than than	ᄚ	unle	unk		111001 01 111	orking inc. D	01101	4001011	ou,					
d withi grene ther th	O.	unk 17. Father's Name (First, Middle, L				unk	18	Mother's	Name (F	irst Midd	lle Mai	den Surnam	e)	un
riec rd or the contraction of th		Tr. Father o Hamo (Finet, Middle, E	-401)			GIII			(1		,		-,	un
	9 Be		in (Type Print)	10	h Mailing	Address (S	Street a	and Numb	er or Pui	ral Pouta	Numba	r, City or To	wn State	Zin Code)
snou and N is n	ဥ	13a. Illioilliant 5 Name/Neiationsin	ір (туре, гіпік)	13	_							-	wii, Gtate,	zip code)
Health a item 27		O.C.M.E.		OOk Diese	111 I	Penn S	tre	et B	alti	more	, M	D 212 Oc. Location	01	Chale
_ I :- L		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from		of Disposit tory or othe	ion (Name of er place)	ceme	tery,		Date	2	uc. Location	- City or I	own, State
rages tent of ant: If r othe		4 Donation 5 X Other Spe												
	H	21 Signature of Funeral Service L	icensee	е .	22. Na	ame and Add	ress of	Facility		655		n 1		.
permit. Departn Import injury		1	. wade, 111	rector							W •	Baltin	nore	Street
	/	23a. Part I. Enter the disease, of c	and little that cause	ad the death. Do n		timore					arract	shock or be	aart	Approximate Int
ysician Medical		failure. List only one cause of		eumonia co			irig, su	on as car	alac or re	copilatory	un cot,	SHOOK, OF TH	Juit	Between Onset
aminer		Immediate Cause (Final disease		lerotic Car			N:							Death
		or condition resulting in death)			ratova	Scurai .	ULSe	ase						
		,	Due to (or as a cor		rarova	Scurai	vise	ase						
		Sequentially list conditions,	Due to (or as a corb.		Idiova	Scurai I	иse	ase						
Н.	ner	Sequentially list conditions, if any, leading to immediate		nsequence of).	Idiova	Scurai	vise	ase						
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a conc.	nsequence of).	i di Tova.	Scurai	vise	ase						
ted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a cor c. Due to (or as a cor	nsequence of).	i di ova.	Scurai	UISE	ase						
xecuted n and - transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor c. Due to (or as a cor d.	nsequence of): nsequence of):					// T +	em#Uc	ner M	F. 0856	6/30/(
be executed sician and surial - transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a cor c. Due to (or as a cor d.	nsequence of).					// It	cem#/c 23	perM	E,g856,	6/30/0	
icate be executed physician and the burial - transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE:	b. Due to (or as a col c. Due to (or as a col d. X AMENDED 1 23c. If yes, outo	nsequence of): nsequence of): nsequence of): ten#23a,27 come of pregnancy	,perME	,g855,5 <u>,</u>	/24/	'06 TT			perM a	23d Date of	of delivery)6 TT
sertificate be executed ding physician and se as the burial - transit	n/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a col c. Due to (or as a col d. X AMENDED i 23c. If yes, outce 1 Live birth	nsequence of): nsequence of): nsequence of): tem#23a,27 come of pregnancy	,perME 2 ☐ Feta	, g855 , 5	/24/				perM)6 TT
rath certificate be executed attending physician and ouse as the burial - transit	n/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as a cord. Due to (or as a cord. X AMENDED 1 23c. If yes, oute 1 Live birth 4 Pregnant	nsequence of): nsequence of): nsequence of): tem#23a,27 come of pregnancy	,perME 2 ☐ Feta	,g855,5 <u>,</u>	/24/	'06 TT			perM a	23d Date of	of delivery)6 TT
he death certificate be executed y the attending physician and hed for use as the burial - transit	n/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	b. Due to (or as a cood. Due to (or as a cood. AMENDED 1 23c. If yes, outc. 1 Live birth 4 Pregnant 9 Unknown	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death	,perME 2	, g855 , 5 al death er (Specify)	/ 24 /	O6 TT	oregnand	Бу		23d Date of Month	of delivery Di	06 TT ay Year
that the death certificate be executed ed by the attending physician and detached for use as the burial - transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as a cood. Due to (or as a cood. AMENDED 1 23c. If yes, outc. 1 Live birth 4 Pregnant 9 Unknown	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death	,perME 2	, g855 , 5 al death er (Specify)	/ 24 /	O6 TT	oregnand	23e. D	id toba	23d Date of Month	of delivery Da	Of TT ay Year ne cause of death
ires that the death certificate be executed signed by the attending physician and I be detached for use as the burial - transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	b. Due to (or as a cood. Due to (or as a cood. AMENDED 1 23c. If yes, outc. 1 Live birth 4 Pregnant 9 Unknown	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death	,perME 2	, g855 , 5 al death er (Specify)	/ 24 /	O6 TT	oregnand	23e. D		23d Date of Month	of delivery Da	06 TT ay Year
requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial - transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	b. Due to (or as a cord. Due to (or as a cord. AMENDED 1 23c. If yes, outc. 1 Live birth 4 Pregnant 9 Unknown	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death	,perME 2	, g855 , 5 al death er (Specify)	/ 24 /	O6 TT	oregnand	23e. D 1	rid toba Yes Vas an	23d Date of Month cco use cont 2 No 3	of delivery Discribute to the Proba	Year ne cause of death ably 4 ☑ Unkno
law requires that the death certificate be executed has been signed by the attending physician and a 2 should be detached for use as the burial - transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	b. Due to (or as a cord. Due to (or as a cord. AMENDED 1 23c. If yes, outc. 1 Live birth 4 Pregnant 9 Unknown	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death	,perME 2	, g855 , 5 al death er (Specify)	/ 24 /	O6 TT	oregnand	23e. D 1 24a V a	id toba	23d Date of Month cco use cont 2 No 3 24b.	ribute to the ware auto-	Ay Year The cause of death Ably 4 1 Unknown opsy findings avai Impletion of cause
The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	b. Due to (or as a cord. Due to (or as a cord. AMENDED 1 23c. If yes, outc. 1 Live birth 4 Pregnant 9 Unknown	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death	,perME 2	, g855 , 5 al death er (Specify)	/ 24 /	O6 TT	oregnand	23e. D 1 24a V a	id toba Yes Vas an utopsy erforme	23d Date of Month cco use cont 2 No 3 24b.	of delivery Discribute to the Proba	Ay Year The cause of death Ably 4 1 Unknown opsy findings avai Impletion of cause
ion: The law requires that the death certificate be executed certificate has been signed by the attending physician and ctor, page 2 should be detached for use as the burial - transit	Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	b. Due to (or as a cold. Due to (or as a cold. X AMENDED 1 23c. If yes, outc. 1 Live birth. 4 Pregnant. 9 Unknown ons contributing to de	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death	,perME 2	, g855 , 5, al death er (Specify) nderlying cau	/24// 3 sise give	O6 TT	oregnand	23e. D 1 24a V a 1 ✓ Y	vid toba Yes Vas an utopsy erforme es 2	23d Date of Month cco use cont 2 No 3 24b.	ribute to the ware auto-	Ay Year The cause of death Ably 4 1 Unknown opsy findings avai Impletion of cause
vsician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	o Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr. Part II. Other significant conditions.	b. Due to (or as a cold. Due to (or as a cold. AMENDED 1 23c. If yes, outder 1 Live birth 4 Pregnant 9 Unknown ons contributing to de	nsequence of): nsequence of): ten#23a,27 come of pregnancy at time of death	,perME 2	,g855,5 al death er (Specify) nderlying cau	/24// 3 sise give	O6 TT	oregnand	23e. D 1 24a V a 1 ✓ Y	vid toba Yes Vas an utopsy erforme es 2	23d Date of Month cco use cont 2 No 3 24b.	ribute to the ware auto-	Ay Year The cause of death Ably 4 1 Unknown opsy findings avai Impletion of cause
g Physician: The law requires that the death certificate be executed for this certificate has been signed by the attending physician and nearl director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	b. Due to (or as a cond. Due to (or as a cond. AMENDED 1 23c. If yes, oute 1 Live birth 4 Pregnant 9 Unknown ons contributing to de	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death eath but not resulting	, perME 2 Fete 5 Oth	,g855,5 at death er (Specify) anderlying cau 26.F 3 \[\] DOA	3 size give	O6 TT	oregnand I. Check on	23e. D 1 24a V a 1 ✓ Y Vily one) Home 5	yes Vas an utopsy erforme es 2	23d Date of Month cco use cont 2 No 3 24b.	of delivery Distribute to the second of the	Ay Year The cause of death Ably 4 1 Unknown opsy findings avai Impletion of cause
ling Physicians. The law requires that the death certificate be execu. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tra	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant conditions of the condi	b. Due to (or as a cold. C. Due to (or as a cold. X AMENDED 1 23c. If yes, oute 1 Live birth 4 Pregnant 9 Unknown ons contributing to de 1 Hospital: 1 Inpa 28a. Date of I (Month, Da	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death eath but not resulting	perME 2 Feta 5 Oth ng in the ur	,g855,5 at death er (Specify) anderlying cau 26.F 3 \[\] DOA	/24// 3 sise give Ot Ot Injury :	Ectopic ren in Part	Check on Nursing	23e. D 1 24a V a 1 ✓ Y Vily one) Home 5	yes Vas an utopsy erforme es 2	23d Date of Month cco use cont 2 No 3 24b.	of delivery Distribute to the second of the	Ay Year The cause of death Ably 4 1 Unknown opsy findings avai Impletion of cause
ling Physicians. The law requires that the death certificate be execu. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tra	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant conditions of the condi	b. Due to (or as a cold. C. Due to (or as a cold. X AMENDED 1 23c. If yes, outder the pregnant of the pregn	nsequence of): nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death eath but not resulting teath but not resulting attent 2 ER/C	, perME 2 Feta 5 Oth ng in the ur Outpatient Time of Inj	,g855,5, al death er (Specify) nderlying cau 26.F 3 DOA jury 28c. 1	/24/ 3	Death (Cher'4 at Work?	Check on Nursing	23e. D 1 24a V a 1 7 Y 1 V One) Home 5	yes Vas an utopsy erforme es 2 Re Reibe hov	23d Date of Month cco use cont 2 No 3 24b. dd? No sidence 6	of delivery Distribute to the second of the	Ay Year The cause of death Abby 4 Unknown Appsy findings avail Ampletion of cause Abs 2 N
fing Physicians. The law requires that the deam certificate be execut. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tra	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unker Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could	b. Due to (or as a cold. C. Due to (or as a cold. X AMENDED 1 23c. If yes, outder the pregnant of the pregn	nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death eath but not resulting	, perME 2 Feta 5 Oth ng in the ur Outpatient Time of Inj	,g855,5, al death er (Specify) nderlying cau 26.F 3 DOA jury 28c. 1	/24/ 3	Death (Cher'4 at Work?	Check on Nursing	23e. D 1 24a V a 1 Y Y Ily one) Home 5 8d Descr	yes Vas an utopsy erforme es 2 Re Reibe hov	23d Date of Month cco use cont 2 No 3 24b. d? No sidence 6	of delivery Distribute to the second of the	Ay Year The cause of death Ably 4 1 Unknown opsy findings avai Impletion of cause
optial or Attending Physician: The law requires that the death certificate be executions after death. neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Sertification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could detern	b. Due to (or as a cold. C. Due to (or as a cold. X AMENDED 1 23c. If yes, outder the pregnant of the pregn	nsequence of): nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death eath but not resulting teath but not resulting attent 2 ER/C	, perME 2 Feta 5 Oth ng in the ur Outpatient Time of Inj	,g855,5, al death er (Specify) nderlying cau 26.F 3 DOA jury 28c. 1	/24/ 3	Death (Cher'4 at Work?	Check on Nursing	23e. D 1 24a V a 1 Y Y Ily one) Home 5 8d Descr	yes Vas an utopsy erforme es 2 Reibe hov	23d Date of Month cco use cont 2 No 3 24b. d? No sidence 6	of delivery Distribute to the second of the	Ay Year The cause of death Abby 4 Unknown Appsy findings avail Ampletion of cause Abs 2 N
spiral or Attending Physician: The law requires that the death certrificate De executiours after death. neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - range.	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendi Invest 3 Suicide 6 Could detern 29a. Certifier 1 Certifying Ph.	b. Due to (or as a cold. C. Due to (or as a cold. X AMENDED 1 23c. If yes, outder the pregnant of the pregn	nsequence of): nsequence of): nsequence of): ten#23a,27 come of pregnancy at time of death eath but not resulting attent 2 ER/C njury 28b. f Injury - At home, f	perME 2 Feta 5 Oth Outpatient Time of Inj	,g855,5 al death er (Specify) nderlying cau 26.F 3 DOA jury 28c. 1 t, factory, offi	/24// 3	F Death (Cher, at Work?	Check on Nursing 20 No 20 one, and do	23e. D 1 24a V a p Y Ily one) Home 5 8d Descr 8f. Location or Tow	Yes Vas an utopsy Re Reibe how	23d Date of Month cco use cont 2 No 3 24b. 24b. sidence 6 v injury occur et and Numle)	of delivery Distribute to the second of the	ay Year ne cause of death ably 4 Unknot opsy findings avai mpletion of cause 2 N al Route Number,
spiral or Attending Physician: The law requires that the death certificate be executiours after death. neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - rank	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendi Invest 3 Suicide 6 Could detern 29a. Certifier 1 Certifying Ph.	b. Due to (or as a cold. C. Due to (or as a cold. X AMENDED 1 23c. If yes, outder the pregnant of the pregn	nsequence of): nsequence of): nsequence of): ten#23a,27 come of pregnancy at time of death eath but not resulting attent 2 ER/C njury y, Year) f Injury - At home, 1	perME 2 Feta 5 Oth Outpatient Time of Inj	,g855,5 al death er (Specify) nderlying cau 26.F 3 DOA jury 28c. 1 t, factory, offi	/24// 3	F Death (Cher, at Work?	Check on Nursing 20 No 20 one, and do	23e. D 1 24a V a p Y Ily one) Home 5 8d Descr 8f. Location or Tow	Yes Vas an utopsy Re Reibe how	23d Date of Month cco use cont 2 No 3 24b. 24b. sidence 6 v injury occur et and Numle)	of delivery Distribute to the second of the	ay Year ne cause of death ably 4 Unknot opsy findings avai mpletion of cause 2 N al Route Number,
uspiral or Attending Physician: I ne law requires that the activities of the attending physician and neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - tra	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendi Invest 3 Suicide 6 Could detern 29a. Certifier 1 Certifying Ph.	b. Due to (or as a cold. C. Due to (or as a cold. X AMENDED 1 23c. If yes, outder the pregnant of the pregn	nsequence of): nsequence of): nsequence of): ten#23a,27 come of pregnancy at time of death eath but not resulting attent 2 ER/C njury y, Year) f Injury - At home, 1	perME 2 Feta 5 Oth Outpatient Time of Inj	,g855,5 al death er (Specify) nderlying cau 26.F 3 DOA jury 28c. 1 t, factory, offi	/24/ 3	Death (Cher4 at Work? s 2 1 1 ding, etc.	Check on Nursing 20 No 20 one, and do	23e. D 1 24a V a p Y Ily one) Home 5 8d Descr 8f. Location or Tow	Yes Vas an utopsy erformes 2 Re Re ibe hov	23d Date of Month ccco use cont 2 No 3 24b. sidence 6 vinjury occur set and Numl e) s) and manne d place, and	of delivery Discribute to the series of the	ay Year ne cause of death ably 4 Unknot opsy findings avai mpletion of cause 2 N al Route Number,
spiral or Attending Physician: The law requires that the death certificate be executions after death. neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transmission.	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendia Invest 3 Suicide 6 Could detern 29a. Certifier 1 Certifying Phyone) 2 Medical Exam	b. Due to (or as a cold. C. Due to (or as a cold. X AMENDED 1 23c. If yes, outder the pregnant of the pregn	nsequence of): nsequence of): nsequence of): ten#23a,27 come of pregnancy at time of death eath but not resulting attent 2 ER/C njury y, Year) f Injury - At home, 1	perME 2 Feta 5 Oth Outpatient Time of Inj	,g855,5,5,al death er (Specify) aderlying cau 26.F 3 DOA jury 28c. 1 t, factory, offi ed at the tim on, in my opi 29c. Lice	/24/ 3	F Death (Chery at Work?	Check on Nursing 20 No 20 one, and do	23e. D 1 24a V a p Y Ily one) Home 5 8d Descr 8f. Location or Tow	Yes Yes Vas an utopsy erformed a comparison of the comparison of	23d Date of Month cco use cont 2 No 3 24b. 24b. sidence 6 vinjury occur eet and Numle e) 3) and manned d place, and	of delivery Distribute to the series autoprior to condeath? Other: Other: Order or Rura oer or Rura er as started due to the med (Mon.)	ay Year ne cause of death ably 4 Vunkno posy findings avai mpletion of cause 2 N al Route Number, edd cause(s)
spiral or Attending Physician: The law requires that the death certificate be executions after death. neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transmission.	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could deterr 4 Homicide 29a. Certifier 1 Certifying Phyone) 29b. Signature and title of certifier	Due to (or as a condition of the best of niner: On the basis of eand manner state) Due to (or as a condition of the basis of eand manner state)	nsequence of): nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death eath but not resulting attent 2 ER/C njury 28b. f Injury - At home, 1 f my knowledge, de xamination and/or and.	perME 2 Feta 5 Oth Outpatient Time of Inj	,g855,5,5,al death er (Specify) aderlying cau 26.F 3 DOA jury 28c. 1 t, factory, offi ed at the tim on, in my opi 29c. Lice	/24/ 3	F Death (Chery at Work?	Check on Nursing 20 No 20 one, and do	23e. D 1 24a V a p Y Ily one) Home 5 8d Descr 8f. Location or Tow	Yes Yes Vas an utopsy erformed a comparison of the comparison of	23d Date of Month ccco use cont 2 No 3 24b. sidence 6 vinjury occur set and Numl e) s) and manne d place, and	of delivery Distribute to the series autoprior to condeath? Other: Other: Order or Rura oer or Rura er as started due to the med (Mon.)	ay Year ne cause of death ably 4 Vunkno posy findings avai mpletion of cause 2 N al Route Number, edd cause(s)
uspiral or Attending Physician: I ne law requires that the activities of the attending physician and neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - tra	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could detern (Check only one) 2 Medical Exam 29b. Signature and title of certifier 30. Name and address of person of the person of	b. Due to (or as a cord. C. Due to (or as a cord. AMENDED i 23c. If yes, outc. 1 Live birth. 4 Pregnant. 9 Unknown ons contributing to de. Hospital. Inpa. 28a. Date of I. (Month, Da. ing. itigation and the contribution of the best of onliner: On the basis of eand manner state. Who completed cause of the cause of the completed cause of th	nsequence of): nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death eath but not resulting atient 2 ER/C injury 28b. if Injury - At home, if if my knowledge, de examination and/or of death (Item 23a)	perME perME perME outpatient Time of Injury farm, street eath occurre investigation	, g855, 5, 5, al death er (Specify) nderlying cau 26.F 3 DOA jury 28c. 1 1, factory, offined at the timon, in my opi 29c. Lic O	/24/ 3	Ectopic pen in Part f Death (Cher'4 at Work? s 2 1 h ding, etc. e and place death occumumber E.	Check on Nursing	23e. D 1 24a V a 1 Y Ily one) Home 5 8d Descr 8f. Location Tow ue to the time, c	Yes Yes Vas an utopsy erformed a comparison of the comparison of	23d Date of Month cco use cont 2 No 3 24b. 24b. sidence 6 vinjury occur eet and Numle e) 3) and manned d place, and	of delivery Distribute to the series autoprior to condeath? Other: Other: Order or Rura oer or Rura er as started due to the med (Mon.)	ay Year ne cause of death ably 4 Vunkno posy findings avai mpletion of cause 2 N al Route Number, edd cause(s)
spiral or Attending Physician: The law requires that the death certrificate De executiours after death. neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - range.	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendi Invest 3 Suicide 6 Could deterring the condition of the conditi	b. Due to (or as a cond. C. Due to (or as a cond. X AMENDED 1 23c. If yes, outd. Pregnant 9 Unknown ons contributing to defined (Month, Darrich Land Berry) 28a. Date of I (Month, Darrich Land Berry) 28a. Date of I (Month, Darrich Land Berry) 28a. Date of I (Month, Darrich Land Berry) 28a. Place of (Month, Darrich Land Berry) 28b. Place of (Specify)	nsequence of): nsequence of): nsequence of): tem#23a,27 come of pregnancy at time of death eath but not resulting atient 2 ER/C injury 28b. if Injury - At home, if if my knowledge, de examination and/or of death (Item 23a)	perME perME perME permental forms putpatient Time of Injuine forms permental forms p	, g855,5,5, al death er (Specify) nderlying caused at the time on, in my oping 29c, Lic. On Street,	/24/ 3	Ectopic pen in Part f Death (Cher'4 at Work? s 2 1 h ding, etc. e and place death occumumber E.	Check on Nursing	23e. D 1 24a V a 1 Y Ily one) Home 5 8d Descr 8f. Location Tow ue to the time, c	Yes Yes Vas an utopsy erformed a comparison of the comparison of	23d Date of Month cco use cont 2 No 3 24b. 24b. sidence 6 vinjury occur eet and Numle e) 3) and manned d place, and	of delivery Distribute to the series autoprior to condeath? Other: Other: Order or Rura oer or Rura er as started due to the med (Mon.)	ay Year ne cause of death ably 4 Vunkno posy findings avai mpletion of cause 2 N al Route Number, edd cause(s)

DHMH 17 Rev 1/2001 OCME 10/2003

ORIGINAL

			1 - For State Registrar	State of Marylan	•	rtment of		nd Ment		ene	6	13084
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		Har-		2	A	ate of Death Month	Day 21 2	Year	3. Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution, give state) The Johns Hopt 5. Social Security Number 217-40-0070	/ · 11 · · ·				4 Hrs. 8. D.	ate of Birth Month, Day,	4c. County N/ Year) L,1942	9. Birthpl	ace (State or Foreign rland
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Balt	imore 10c. Cit	y, Town or Loc		sedale				10	0d. Inside City Limits 1 ☐ Yes 2X No
	with the 3a or 28e Iten all	Funeral Directo	10e. Street and Number 5704 Daybreak Ter	race		10f. Zip Cod	21206		10	og. Citizen of V		•
936	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural; or items 23s or 28s-f ehow aumstic event, the Medical Examinar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	If	/as Decedent of Yes, specify C	of Hispanic Original	in? (Specify) Puerto Rican	Yes or No- n, etc.)		e - Americ ck, White, e	
Maryland 21215-0036	within 72 hor ene. then "netur	Completed	15. Decedent's Educ (Specify only highest grade		(Give k life. D	ent's Usual Oc ind of work do O NOT use rei ecreta:	ne during most ired)	of working		Baltin		,
/land 2	uld be filed Mental Hygi arked other atic event, I	To Be Co	12 Years 17. Father's Name (First, Middle, Last) Carter H. Marshal	.1		ecreca	18. Mother			Maiden Suman Kutaici	ne)	, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
, Mar	permit. Pages 1 and 2 should by Department of Heatth and Menta importent: If item 27 is marked eny injury or other traumatic evone.		19a. Informant's Name/Relationship (Type Mr. Bill A. Hartl	ove (Husband	5704	Daybre		ac e R	os e da	le, Mar	yland	21206
Baltimore,	Pages 1 Iment of H tent: if ite		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		atory or other p	esus Çer			20c. Location - 6 Dunc	•	wn, State Maryland
Ball	Departition Depart		21. Signifure of fineral first to se	Mont	7	uda-Ru 922 Wi:	dress of Facility ck Fune: se Ave.	ral Ho Dunda	lk, Ma	ryland		22
	To the Hospitel or Attending Physician: The law requires that the death certificete be executed To within 24 hours eligine death. To the Funder Director: After this certificate has been signed by the attending physician and Mobilian properties of the Funder Director. After this certificate has been signed by the attending physician and Mobilian physician and Mobilian physician and Mobilian physician by the funderal director, page 2 should be detached for use as the burial-transit of properties.	lical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	y Hyr yueace of): J ermo	perter			priatory arre			Approximate Interval Between Onset and Death 10 years
P.O. Box 6	uires that the death certifics signed by the attending ph d be detached for use es t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ıl déath 3 □l	Ectopic pregna Other (specify					te of delive	ry Day Year
Records, P.	w requires that t been signed by should be deta	<u>م</u>	Α	we Pulmona	_	derlying cause				acco use cont	tribute to th	e cause of death? ably 4 Munknown
al Rec	iician: The law r certificete hes be rector, page 2 sh	e Completed	Ling Cancer 25. Was case referred to medical					1		No No	prior to con death?	osy findings available npletion of cause of
Division of Vital	To the Hospitel or Attending Physician: The within 24 hours eiter death. To the Funerel Director: After this cartificate he completely filled in by the funeral director, page	ToB	examiner?	ospital: 1 atient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. I	Othor	28d. [5 🗌 Reside	nce 6 □Oth w injury occur)
Divis	To the Hospitel or Attent within 24 hours effer deatl To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, stre fy)	et, factory, offi	се		ocation (Str City or Town		per or Rura	Route Number,
	the Hospi in 24 hou the Funer pletely fill	Medical	(Check only 2 Medical Examin one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	estigation, in m	ny opinion, death	d place, and d h occurred at	the time, da	ite and place,	and due to	the cause(s)
)	To T	2	29b. Signature and title of certifier	- , MD			ense number	00		ord 2		
10	Sta Registi		Army De Terror (31. Date filed (Month, Day, Year)	npleted cause of death (Iter OO VO 1 +1 32. Registrar's Signa	TI 23a) (Type, F	Print)	irrect	Baltiv	nore,	margla	rd s	F3611

			For Amend Ite	ons 23a,	ate of M 24a, 2	aryland	d / Depa 27 per	artment of F	lealth and Death 26	d Mental H /06dhb	giene Reg. No.	006	3085
			1. Decedent's Name (First, Mic	idle, Last)						2. Date of D	eath Day	/ Year	3. Time of Death
4	Physici /Medic		James L. Hil	l Sr						April	Day		1649 M
	Examin		4a. Facility Name (If not institu	ion, give street	and number)			4b. City, Town, o	r Location of D	eath	4c.	County of Death	
-				rutan		pita			more				
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2		ge (In yrs. 1 62	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I	Ain. (Month, L	ay, Year)	Coun	**
	Director	-	219-42-5404 Usual Residence of Decedent			02				Dec 2	5, 19	43 Mary	Land
	yland low		10a. State 10b. Cour	nty		10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	Mar st	tor	MD Balt:	more			Parkv	ille					1 ☐ Yes 2√ No
	or 28	Director	10e. Street and Number					10f. Zip Code			10g. Citi	zen of What Coun	try?
	23a		2606 Canterbu						.234		L	USA	
	ar dex	Funeral	11. Marital Status	Ar	as Decedent med Forces?	?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pi	? (Specify Yes or Nuerto Rican, etc.)	lo-	 Race - America Black, White, et 	
36	rs aft	by F	1 ☐ Never Married 2 ☐XN 3 ☐ Widowed 4 ☐ Divord	. If	☐ Yes 2) Yes, Give ear or Dates:	INO		1 ☐ Yes 2 🙀 No	Specify:			Specify: wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ta M. Jical Ex. niber in ust be notified a			ent's Education				ient's Usual Occup		S. A	16b. Ki	nd of Business/Inc	lustry
215	Bn n	Completed	(Specify only hig Elementary/Secondary (0-12		ollege (1-4or	5+)	life.	kind of work done DO NOT use retired	during most or d)	working			
2	e filed within al Hygiene. I othar than ' vant, II e M.	Con	5		0			pipe fi				o Cup Co	rp
nd	tal Hild oth	Be	17. Father's Name (First, Midd	le, Last)				unk	-	Name (First, Midd	<i>e, Maide</i> n	Sumame)	
3	2 should be and Mental is marked raumatic av	J.	19a, Informant's Name/Relation	nehin (Tuna Pi	rint)		10h Mailir	ng Addross /Street		ne Hill r Rural Route Num	her City o	r Town State Zin	Code
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If Item 27 is marked other than 'natural', or Items 23a or 28a-1 show or other traumatic event, it a Modical Examination as the modified at	1 4	Barbara Hill	, , , , ,	1111/		F						ŕ
	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	spouse			lace of Dispo	sition (Name of		d Parkvil		$rac{MD}{D}$ 21234 exation - City or To	
υOΠ	Pages nent of int; If it iry or o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Burial 2 ☐ Cremation 1 ☐ Other		al from State		ытычығу, сты	natory or other plac	(8)				
Baltimore,	permit. Pages Department of H Important; If Its any Injury or of		21. Sign fure Eureral Serv Ron 1		e, Dir	ector	c S	Name and Addre	ss of Facility	ard 655 W	. Bal	ltimore S	treet
			23a. Part Enter the disease	or complication	s that cause	d the death		altimore, er the mode of dvir		L201 diac or respiratory	arrest.		Approximate
			shock or heart failure. I	ist only one cau	on each I	ine.	Arte	ciosclero		rdiovascu		Disease	Interval Between Onset and Death
1	Pn ysici an /Medical		disease or con hion resulting in death)	a	Due to (or as			mary	-	-		-	
	Examiner			b. —	,								
	D ==	ner	Sequentially list conditions, if any, leading to influediate cause. Enter Underlying	J "	Oua to (or as	a consequ	uanda of):						
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as								
8760,	cate be executed physician and the burial-transit		Tooling III additiy East		Due to (or as	a consequ	derice of).						
387		dicai		d									
9 X	The law requires that the death certific the has been signed by the attending p page 2 should be detached for use as!	/Me	IF FEMALE: 23b. Was decedent pregnant		yes, outcome							23d. Date of delive	rv
Box	death a atter d for u	Physician/M	in the past 12 months?	4	□Live birth □Pregnant a			Ectopic pregnancy Other (specify)					Day Year
0.	at the de by the a tached	hys	9 Unknown	91	Unknown								
S, D	es tha igned l	ру Р	Part II. Other significant cond	litions contribut	ing to death I	but not rest	ulting in the u	nderlying cause giv	en in Part I.			ise contribute to th	
ord	w require been si should t									_ 1	Yes 2	□No 3□Prob	ably 4 □Unknown
Records,	e lawr has be je 2 sh	ompieted							. <u>.</u>	24a. Wa	opsv	prior to con	osy findings available apletion of cause of
H		Con								1 ☐ Yes	formed? 2.0 No	death?	2 No
Vital	Physician: 1 this certifical ral director, p	Be	25. Was case referred to med examiner?	ical Hospit	al·			t 20 DOA Oth	0.00	Death (Check only			
of	Phys this al dii	٠ <u>۲</u>	1 ☐ Yes 2 ☐ Xio 27. Manner of Death		a. Date of Inj	- 1	ER/Outpatier 28b. Time o	I JUDOA	4	ng Home 5 Re 28d. Describe)
o	ding h. h. After funer	tion	1 ☐ atural 5 ☐ Per		(Month, Da	ay Year)	Injury	Wor	k? Yes 2□No			,	
Division	I or Attandi after death. Diractor: A	fica	3 ☐ Suicide 6 ☐ Col	ld not be	e. Place of In	jury - At ho	me, farm, str	eet, factory, office		28f. Location	(Street an	d Number or Rura	Route Number,
Ö	al or A s after il Dirac	Certification:	4 Homicide		bullaing, e	tc. (Specif)	7)			City or 1	own, State)	
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: Afte completely filled in by the fune	edical (29a. Certifier 1 Certi (Check only one) 2 Medi	ying Physician cal Examiner: (To the best on the basis on and manner s	of my kno of examina tated.	wledge, deat tion and/or in	n occurred at the tirvestigation, in my o	ne, date and p pinion, death o	lace, and due to the	e cause(s) e, date and	and manner as st place, and due to	ated. the cause(s)
	To the Within To the	Me	29b. Signature and title of cer	itier				29c. Licens				e signed (Month, I	
			1 7	The	e			20	0182	30	AP	RIL 4,	2006
•			30. Name and address of pers	and the same of th				Print)	١	7	D:	+ 1	2006 ove HD 21239
			Kalathil		shid	HARM	IM, MI	5601	Lock	n Kaven	KIM	, Baltim	ove HD 21239
	Sta		31. Date filed (Month, Day, You APR 2, 6, 200	207	32. Regist	rar's Signa	fure (1)					,	
	Regist	eli	APR 2 6 200	U JAKER	All Series								

I

Physician Adma Ann Howe April 193 20 193 4 : 26 pm April 193 20 1				1 - For State Registrar	State of Ma	iryland /		nent of F			Reg. No.	UUO	13086
Prince George's Hospital Center. Character Charac				Alma Ann Howe						April	14	2006	3. Time of Death 4:26pm M
Use Part Action December 100 City Town or Location 101 Zer Case 105 City 100 City	/ F	uneral	ier	Prince George's H 5. Social Security Number 6. S	ospital Ce	(In yrs. last bi	rthday) If	Chevery Under 1 Year	2y If Under 24 Hrs	8. Date of Bi	Pr	ince Geo	onge s
Helen Hewett Security Securi	yłand	wow.					m or Location	on		10.7007			10d. Inside City Limits
William Thompson Helen Hewett Thompson Helen Hewett Thompson Helen Hewett Helen Helen Hewett Helen	h the Ma	or 28a-1 s a notified	Irector		eorge's	Lanhan		Of. Zip Code			10g. Citi:	zen of What Cou	1X Yes 2 No untry?
William Thompson Helen Hewett Thompson Helen Hewett Thompson Helen Hewett Helen Helen Hewett Helen	₩.	238		6217 Brightlea Dr	ive			20706			US,	A	
William Thompson 19b. Mailing Address (Street Authors of Plural Rouse Number of Plural	136 rs after dea	r, or items zaminer m	oy Funer	1 Never Married 2 Married	Armed Forces? 1 ☐Yes 2X N If Yes, Give					Specify Yes or No to Rican, etc.)		Black, White,	, etc.
William Thompson 19b. Mailing Address (Street Authors of Plural Rouse Number of Plural	215-00 hin 72 hou 9.	no "natura Medical E	pleted	15. Decedent's Ec (Specify only highest gra	ucation de completed)		Decedent' (Give kind life. DO	s Usual Occup of work done o VOT use retired	ation during most of wo	rking			
Bay	21.2 bed with	T.	Com		3011aga (1-4013	7	Home	maker				Home	
Physician Medical Examiner Particular Beass of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Particular Beass of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	Vland vuld be file Mental Hy	arked oth	Be								, Maiden	Sumame)	
Physician Medical Examiner Ph	2 sho	is m			ype, Print)							r Town, State, Zij	p Code)
Physician Medical Examiner Ph	C, P	em 27 thar t				20h Place o	17 Br	ightled	r Drive.				in Ctata
Physician Medical Examiner Ph	ages ont of	t: # lk y or o		1 Burial 2 □ Cremation 3 □	Removal from State								
Physician Medical Examiner Ph	altir nit. P vartme	orten injur	1			weskey							ace, MV
Physician (Present and Cause (Final Examiner) Sequentially fist conditions (Final Examiner) Sequential Examiner (Fina	n ga	e o		sitaine M. Sn	ith-Bi	moo	123	chell-S S Wash	Smith Fu Linatan	neral Ho Hauro d	me,	P.A.	21078
Part Company	Phys	sician		Immediate Cause (Final			not enter th	e mode of dyin	g, such as cardia	c or respiratory a	rrest,		
FFMALE 23b. Was decedent pregnant in the past 12 modfls? 1 1 1 1 1 1 1 1 1	Exa	hysician and the burial-transit		that initiated events	b. Dissectin Due to (or as a	g aneu	rysm of):	of des	cending	thoracio	e aor	ta	
25. Was case referred to medical examiner?	∪ :=	uttending or use as		23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 • No	1 ☐Live birth 2 4 ☐ Pregnant at t	Fetal death					2		
25. Was case referred to medical examiner?	rdS, F	sign d b	þ		ontributing to death bu	t not resulting i	n the under	ying cause give	en in Part I.				/
The state of the s	The law re	age 2	omplet							autop	psy ormed?	prior to co death?	empletion of cause of
The part of the pa	7123 Sien:	artifica ictor,	a						26. Place of Dea			, 2, 100	
1 Matural 2 Accident 3 Suicide 4 Homicide 5 Place of Injury - At home, farm, street, factory, office 2 Set. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didle of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)		w =	2	1 ☐ Yes 2 ☐ No	1 h inpatien			□ DOA Cthe	er: 4 🗌 Nursing F				fy)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print)	E 6	After	catlon:	1 Natural 5 Pending 2 Accident investigation			njury N	1 1 0					
29b. Signature and title of certifier Power a Succession of Death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) April 14, 2006	DIVI	in b		4 Homicide determined	building, etc.	(Specify)				City or To	wп, State)		
Partia Suma D0057636 April 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	the Hosp nin 24 hou	the Fune	ledical	one)	iner: On the basis of	examination ar	e, death occ id/or investig	gation, in my op	oinion, death occu	e, and due to the urred at the time,	date and	place, and due to	o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Towith	10	2		6								
7 1		_			ac-				7636		Apı	rıl 14, 2	2006
a latitude double boot mospitud direct once and and accept the second	,	7							MD 207	85			
State 31. Date filed (Month, Day, Year) APR 2 6 2006 32. Registrar's Signature	***			31. Date filed (Month, Day, Year)			Lan	des,		<u> </u>			

		1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>		of Health and of Death		ieņe _{g. No.} 0 0	6	13087
Phys	inian	Decedent's Name (First, Middle, and American State of Company)	Last)				2. Date of Deat Month	h Day	Year	3. Time of Death
Phys: /Me	dical	ROSA LEE HA	AYES				April 2			8:30 P M
Exam	niner	4a. Facility Name (If not institution, g	give street and numbe	r)	4b. City, Tov	n, or Location of Dea	h	4c. County	of Death	
		Greater Baltim				owson		Bal	timor	
Funera			. Sex 7 1 ☐ M 2 ☐ ▼F	Age (In yrs. last birthday) 81 Yrs.		ear If Under 24 Hrs ays Hours Min		Year)	9. Birthp Coun	lace (State or Foreign try)
Directo	or	242-38-8735 Usual Residence of Decedent	21	01 115.			07/24/	1924	N. (CAROLINA
land w		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
Mary	호	MD N/	Α	BALTIM	ORE CI	TY				XXYes 2 No
r 28e	Director	10e. Street and Number			10f. Zip Co	de	10	0g. Citizen of V	What Coun	itry?
-0036 hours after death with the Maryland tural', or iteme 23a or 28e-f ehow at Examinar must be notilised at		5645 PERDUE	AVENUE		2	1239		US	Α	-,-
death	Funeral	11. Marital Status	12. Was Deceder		Was Decedent	of Hispanic Origin? (S	Specify Yes or No-	14. Rac	e - Americ	an Indian,
or its	Ē	1 Never Married 2 Married				Cuban, Mexican, Puer	to Rican, etc.)		k, White,	
003 0urs	d by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:	1 ☐ Yes 2 🔀	No Specify:		Specify	: BL	ACK
ún ≈ 2 a	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	dent's Usual O	ccupation one during most of wo	rkina	16b. Kind of Bu	usiness/Ind	dustry
within then the Mark	ם	Elementary/Secondary (0-12)	College (1-40	r 5+) life.	DO NOT use re	etired)		VEDTO		
		12TH 17. Father's Name (First, Middle, La	3 YE	ARS NU	RSE	40 14-15-1 15-		MEDIC		
T dans	Be		•				me (First, Middle, M A WILLIA		10)	
Should Should Mark mark	J.			401.44.77						
Ma d 2 s th an 7 ts r traur		19a. Informant's Name/Relationship CAROLYN CHRIST		UGHTER 2	07 C E	reet and Number or Ri RBY AVE.	COPPER	City or Town, RS COV	State, Zip E . T	^{Code)} 'X 76522
		20a. Method of Disposition		20b. Place of Dispe				20c. Location -		
Pages nent of Int. If it		XXBurial 2 ☐ Cremation 3		cemetery, cre	matory`or other	place)	/28/06 H		-	
Baltimore, Dermit. Pages 1 a Department of Hee Important: if tem		4 ☐ Donation 5 ☐ Other (Special Service Licenses)	Carrier Committee				****			
Baltimo permit. Pag Department Important: I		21. Signature Silving Elic	77X X				OWELL FU			
		23a. Part Enter the disease, or co	mplications that caus			BERTY HE			T.I.IW	ORE, MD
	1	23a. Fa41. Enter the Asease, or co shock, or heart ailure. List on Immediate Cause (Final								Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death)	END 7	IAGE CH	RDIO.	myo PA	71+4			
Examine			Due to (or a	TAGE CA s a consequence of): = 571VE	in-A	AT FAL	1E			
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):	[]EIII	-1 -1-	unc		+	
ansit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events	CAD							
O, exec an an rial-tr	Exa	resulting in death) Last	Due to (or a	s a consequence of):		_				
IS, P.O. BOX 68/60, XX res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	dlcal		d ype	4 47	ABET	ES				
tifica gph as th										
Bath cert attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		JEctopic pregna	30CV		23d. Date	e of delive	ry
o dea he att	SICI	in the past 12 months?			Other (specify			Mor	nth	Day Year
T.C.	h	9 □Unknown `								
S, es th igned	þ	Part II. Dther significant conditions	contributing to death	but not resulting in the u	nderlying cause	given in Part I.	23e. Did toba	acco use contr	ibute to the	e cause of death?
w require been si	Completed						1 🗆 Yes	s 2 No	3 🗌 Proba	ably 4 □Unknown
as be	be						24a. Was an autopsy		Vere autop	sy findings available
The The page	ě						perform	ed? d	leath?	
UNISION OT VITAI HECOTGS, to a transition of VITAI HECOTGS, for Attending Physician: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Be (25. Was case referred to medicat examiner?				26. Place of Dea	ath (Check only one			
hysic hysic lisice	10	1 Yes 2 No	Hospital:	ient 2 ER/Outpatier	nt 3 DOA	Other: 4 Nursing H	lome 5 Resider	nce 6 Othe	or (Specify)
ng Pl		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of In (Month, D	ay Year) 28b. Time o	f 28c. I	njury at Work?	28d. Describe how	w injury occurre	be	
SIO	atle	2 Accident investigati	on			1 ☐ Yes 2 ☐ No				
r Att	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of it	njury - At home, farm, strate. (Specify)	eet, factory, off	ce	28t. Location (Stre City or Town,	eet and Numbe State)	or Rural	Route Number,
UIVISION OT VITAI HECORDS, P.O. BOX to the Hospitel or Attending Physician: The law requires that the death certifully 4 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as										
Hosp 4 hou Fune ely fil	ical	29a. Certifier Certifying F	Physician: To the bes aminer: On the basis	t of my knowledge, deatl of examination and/or in stated.	h occurred at th	e time, date and place	, and due to the car	use(s) and mai	nner as sta	ited.
the I hin 2- the B	Medical	COL Simple and title of and title			1 00 1					
To Yest		29b. Signature and title of certifier	1-1-		29c. Lic	ense number	29	d. Date signed	(Month, D	Day, Year)
(mond !	I, hes	7	D:	x184		414	104	
	4	30. Name and address of person where Aymono A 31. Date filed (Month, Day, Year)	o completed cause of	death (Item 23a) (Type,	Print)	00 11	7		(a.) /	1,700
1000		31 Date filed (Month Day Your	VE MI	1801 8	OFE	KN #100	10WS	0~ 1	کر لایا	1204
Regis	tate	APR 2 6	2006	and a digitature	034					

			For State Registrar	State of Man		partment of I			ene 9. No.	13088
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last Lloyd Hamilton					2. Date of Death	22 2000	3. Time of Death
	Examin Funeral	er	4a Facility Name (If not institution, give DETAIN HEAD 5. Social Security Number 6. Se	14h + Re	hab n yrs. last birthda	B		8. Date of Birth (Month, Day, 4/14/18	4c. County of Deal	hplace (State or Foreign
·	Director		551-24-9056 Usual Residence of Decedent 10a. State 10b. County	XM 2□F	88 Yrs.			4/14/18	8 Or	egon 10d. Inside City Limits
	the Maryl 28a-f eho	Director	Maryland Harfo		Belair			10	g. Citizen of What Co	1 ☐ Yes 2X No
	23a o	ai D	1411 Redfield Roa	ıd		2101	.5		U.S.A.	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 ie marked other than "neturel; or Itema 23a or 28a-f ehow other traumatic event, the Modical Exposition or traumatic event, the Modical Exposition of the fourtilled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13	B. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Special, Mexican, Puerto Display Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
21215-0036	within 72 ho ene. then "netur	Completed	15. Decedent's Edd. (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) Year College	(Giv	edent's Usual Occu ye kind of work done DO NOT use retire	during most of work ad)	ing	6b. Kind of Business/	
d 2	il Hygid other	Be Co	17. Father's Name (First, Middle, Last)	. Teal Coll	ege AI	rcrait me	18. Mother's Name	(First, Middle, Ma	Aerospace	Industry
Maryland	ould be Menta arked	ToB	Fred Hamilton				Verna l	Mae Gonde	er	
	and 2 sh alth and 27 ie m er traum	n	19a. Informant's Name/Relationship (T) Gary Hamilton —	rpe, Print) Son			rand Number or Rura Road Be		City or Town, State, 2 21015	(ip Code)
Baltimore,	80=5		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □F	lemoval from State		position (Name of rematory or other pla			0c. Location - City or	
ltim	permit. Par Department Important: eny injury		4 Denation 5 Other (Specify) 21. Signature J Fun ral 200 ice Licens			rematory 22. Name and Addre	4/25/ ess of Facility	'06 Ca	tonsville	, MD
Ba	permit. Departr Importe eny inj	1 1/3	on arm				pel Funera r Road Ba	al Home, altimore.	Inc. MD 2120	6
	Physician /Medical		a3a. Pant. Enter the disease, or complete shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that ceused the cause on each line. a	death. Do not e	nter the mode of dy	heimer	or respiratory arres	nentia	Approximate Interval Between Onset and Death
8,0928	certificate be executed by the following physician and burial-transit and the burial-transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
928	icate by physic s the bu	dicai		J						
10. Box 6	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	☐Ectopic pregnanc	:y		23d. Date of deli Month	very Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the	underlying cause gr	ven in Part I.		acco use contribute to	the cause of death?
Q. ∩ al Reco	The law ate has b page 2 sl	Completed	Failure	to the	1-r1V-6			24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
工業		To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	lospital:	2 ER/Outpatio	ant 3 DOA Ott	26. Place of Death her: 4 Wursing Hor		ce 6 Other (Spec	N(hz)
CLE.	ding h. After fune		27. Mann eath Latural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		of 28c. Inju-		28d. Describe how		ny)
OV	o Pire	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s Specify)	treet, factory, office	1	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
\Box	the Hospitel thin 24 hours a the Funeral I mpletely filled	dicai	29a. Certifier 1 Certifying Physical Canal Cone)	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or i	ath occurred at the ti nvestigation, in my o	ime, date and place, a opinion, death occurre	and due to the cau ed at the time, date	rse(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the Complet	Me	29b. Signature and title of cartifier	m-1/MC		29c. Licens	se number	290	1. Date signed (Month	Day, Year)
	•		30. Name and address of pers who co	empleted cause of deaty	(Item 23a) (Type	p, Print)	1918 5		th. 11 5	2,2006
4.5	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	HD	Abe	endeen	, rary	ard 2001
	Registr	1.0	APR 2 6 2006	Marie A	MARKE					

State of Maryland / Dep. 1 - State Registrar Ce	artment of Health and M rtificate of Death	ental Hygie	4. U U D	13089
1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physician THOMAS JOYC	E	Month	Day Year	0318 AM
Examiner 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMOR			
Funeral Director 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. A	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Countr	
Usual Residence of Decedent		Apr 19,	1941 New Y	ork
10a. State 10b. County 10c. City, Town or Lo	ocation		100	d. Inside City Limits
Baltimore Ess	sex			1 ☐ Yes 2 🔀 No
fine and Number	10f. Zip Code	10g.	Citizen of What Countr	y?
1502 R Galena Road	21221		USA	
MD Baltimore Ess MD Baltimore Ess MD Baltimore Base Ba	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americar Black, White, et	
To be the property of the prop	1 ☐ Yes 2 No Specify:		Specify: whi	te
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unk College (1-4or 5+) Unk	dent's Usual Occupation	unk 16b	. Kind of Business/Indu	stry unk
(Give	kind of work done during most of workii DO NOT use retired)	19		
TO BEEF OF UNK UNK	17			
च में में हैं है । व व व व व व व व व व व व व व व व व व	unk 18. Mother's Name	(First, Middle, Maid	den Sumame)	unk
10a. State 10b. County 10c. City, Town or Letter 10c. City or Letter 1	ng Address (Street and Number or Rura	Pouto Number Ci	hi or Tour State 7in C	No w/o 1
Hopkins Bayview Medical Ctr 4940	Eastern Avenue Ba			ode)
Hopkins Bayview Medical Ctr 4940 20a. Method of Disposition 20b. Place of Disposition			MD 21224 Location - City or Tow	n, State
1 Burial 2 Cremation 3 Removal from State Cemetery, crei	matory or other place)			
21. Signature of Fugeral Serviced icensee	2. Name and Address of Facility tate Anatomy Board	655 W. Ba	altimore St	reet
23a. Part1. Enter the disease, of complications that caused the death. Do not ent	altimore, MD 21201			
snock, or neart tailure. List only one cause on each line.	ter the mode of dying, such as cardiac o	respiratory arrest,	l l	Approximate Interval Between Onset and Death
Physician disease or condition resulting in death) Physician disease or condition resulting in death) A consequence of:	la stroke 11	mylecte	US-	
Examiner alcohol abo	use demossión	0	o Cacl	vic.
Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying. Due to (or as a consequence of):	To Gayverson	roem	acra	ug
ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	(Cidiff			
resulting in death) Last Due to (or as a consequence of):				
cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
IF FEMALE: 23c. If yes, outcome of pregnancy				
23b. Was decedent pregnant in the past 12 months?			23d Data of dalities	
The past of the pa	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	ay Year
1	⊒Ectopic pregnancy ∃ Other (specify)			
IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	Other (specify)	23e. Did tobacc		ay Year
O C S D S C D C D C D C D C D D D D D D D	Other (specify)	23e. Did tobacc	Month D. o use contribute to the	cause of death?
O'd same as the conditions contributing to death but not resulting in the u	Other (specify)	1 ☐ Yes	Month D	ay Year cause of death?
aw requires as been sign 2 should be pleted by	Other (specify)	1 ☐ Yes	O use contribute to the 2 No 3 Probab 24b. Were autops prior to comp death?	cause of death?
U 25. Was case referred to medical examiner?	Other (specify)	1 Yes 24a. Was an autopsy performed: 1 Yes 2	O use contribute to the 2 No 3 Probab 24b. Were autops prior to comp death?	cause of death?
25. Was case referred to medical examiner? 1 N Yes 2 No Hospital: 1 Inpatient 2 K ER/Outpatier	Other (specify)	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one) 6 S Residence	Month o use contribute to the 2 No 3 Probab 24b. Were autops prior to comp death? 1 Yes 2	cause of death?
25. Was case referred to medical examiner? 1 Ness 2 No Hospital: 1 Inpatient 2 Ref/Outpatient 2 Ref/Outpatient 2 Ref/Outpatient 1 No Pending (Month, Day Year)	Other (specify) Inderlying cause given in Part I. 26. Place of Death At 3 DOA Other: 4 Nursing Hon f 28c. Injury at Work?	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one)	Month o use contribute to the 2 No 3 Probab 24b. Were autops prior to comp death? 1 Yes 2	cause of death?
25. Was case referred to medical examiner? 1 Ness 2 No Hospital: 1 Inpatient 2 Ref/Outpatient 2 Ref/Outpatient 2 Ref/Outpatient 1 No Pending (Month, Day Year)	Other (specify) Inderlying cause given in Part I. 26. Place of Death at 3 DOA Other: 4 Nursing Hom by Work? M 1 Yes 2 No	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one) 5 Residence 8d. Describe how in 8f. Location (Street	Month o use contribute to the 2 No 3 Probab 24b. Were autops: prior to comp death? No 1 Yes 2 6 Other (Specify) jury occurred	cause of death? cly 4 M2Unknown y findings available letion of cause of
25. Was case referred to medical examiner? 1 Nes 2 No Hospital: Impatient 2 Ref/Outpatient	Other (specify) Inderlying cause given in Part I. 26. Place of Death at 3 DOA Other: 4 Nursing Hom by Work? M 1 Yes 2 No	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one) 1 Residence 5 Residence 8d. Describe how in	Month o use contribute to the 2 No 3 Probab 24b. Were autops: prior to comp death? No 1 Yes 2 6 Other (Specify) jury occurred	cause of death? cly 4 M2Unknown y findings available letion of cause of
25. Was case referred to medical examiner? 1 Nes 2 No Hospital: Impatient 2 Ref/Outpatient	Other (specify) nderlying cause given in Part I. 26. Place of Death at 3 DOA Other: 4 Nursing Hon f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office 2	24a. Was an autopsy performed 1 Yes 2 (Check only one) 1 Sesidence 3d. Describe how in City or Town, St.	Month Double of the 2 No 3 Probab 24b. Were autops prior to comp death? No 1 Yes 2 6 Other (Specify) girry occurred	cause of death? cause of death? cly 4 \(\overline{\text{ZUnknown}} \) y findings available letion of cause of \(\overline{\text{No No.}} \) Route Number,
25. Was case referred to medical examiner? 1 Nes 2 No Hospital: Impatient 2 Ref/Outpatient	Other (specify) nderlying cause given in Part I. 26. Place of Death at 3 DOA Other: 4 Nursing Hon f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office 2	24a. Was an autopsy performed 1 Yes 2 (Check only one) 1 Sesidence 3d. Describe how in City or Town, St. and due to the cause d at the time, date a	Month Do use contribute to the 2 No 3 Probab 24b. Were autops prior to comp death? No 1 Yes 2 6 Other (Specify) jury occurred and Number or Rural Fate) (s) and manner as stale and place, and due to the	cause of death? cause of death? cly 4 Matunknown y findings available letion of cause of No Route Number, ed. ee cause(s)
The Property of the policy of	Other (specify) nderlying cause given in Part I. 26. Place of Death at 3 DOA Other: 4 Nursing Hom f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office 2 h occurred at the time, date and place, a vestigation, in my opinion, death occurred 29c. License number	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one) 1 Secrete Secrete How in the City or Town, St. and due to the caused at the time, date at 129d. I	Month o use contribute to the 2 No 3 Probab 24b. Were autops prior to comp death? No 1 Yes 2 6 Other (Specify) ijury occurred and Number or Rural Fate) (s) and manner as state and place, and due to the pate signed (Month, Date signed (Month	cause of death? cause of death? ly 4 2 Unknown y findings available letion of cause of No Route Number, ed. ee cause(s) y, Year)
25. Was case referred to medical examiner? 1 Nes 2 No Hospital: Impatient 2 Ref/Outpatient	Other (specify) nderlying cause given in Part I. 26. Place of Death at 3 DOA Other: 4 Nursing Hom f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office 2 h occurred at the time, date and place, a vestigation, in my opinion, death occurred 29c. License number	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one) 1 Secrete Secrete How in the City or Town, St. and due to the caused at the time, date at 129d. I	Month o use contribute to the 2 No 3 Probab 24b. Were autops prior to comp death? No 1 Yes 2 6 Other (Specify) ijury occurred and Number or Rural Fate) (s) and manner as state and place, and due to the pate signed (Month, Date signed (Month	cause of death? cause of death? ly 4 2 Unknown y findings available letion of cause of No Route Number, ed. ee cause(s) y, Year)
25. Was case referred to medical examiner? No construction of the construction of t	26. Place of Death 26. Place of Death 27. Place of Death 28. Injury at Work? M 1 Yes 2 No 29c. License number 29c. License number	1 Yes 24a. Was an autopsy performed 1 Yes 2 (Check only one) 1 Secrete Secrete How in the City or Town, St. and due to the caused at the time, date at 129d. I	Month o use contribute to the 2 No 3 Probab 24b. Were autops prior to comp death? No 1 Yes 2 6 Other (Specify) ijury occurred and Number or Rural Fate) (s) and manner as state and place, and due to the pate signed (Month, Date signed (Month	cause of death? cause of death? ly 4 2 Unknown y findings available letion of cause of No Route Number, ed. ee cause(s) y, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Doris T. Jones April 23° 2008 12:10a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care - Ruxton Towson If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. Aug. 1, 1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 216-03-4103 1 □ M 2 □ XF Maryland 95 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show The Medical Examiner must be notified at MDBaltimore Middle River 1 Tyes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21220 86 West Kingston Park Lane USA "natural", or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker own home 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Rogers Sr. Violet May Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Dalgo /daughter 86 West Kingston Lane Baltimore MD 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Zion Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/26/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 On 23a. Part1. Enter the disease, or complications that caused the death. Definot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Endstag Physician 2 115 /Medical quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). The faw requires that the death certificate be executed burial-transit Exami that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à rsis. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy perfo certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Cther: 1 ☐ Yes 200 No P 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident filled in by the Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 025043 241 who completed cause of death (Item 23a) (Type, Print) 6565N raulkies MD CharlesSt 31. Date liled (Month, Day, Year) 32 Registrar's Signature State APR 2 6 2006 Registrar

			1 - For State Registrar	State of Ma	ryland / Dep	artment of Heal	ith and Me	ental Hyg	_	. 3091
			Decedent's Name (First, Middle, La	st)				2. Date of Deat	th	3. Time of Death
	Physici /Medio		Adele L. Judas					April 2	21, 2006	9:45A M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Loca	ation of Death		4c. County of Deat	
			Wilson Health Ca	ire		Gaithersh			Montgome	ery
	Funeral Director		5. Social Security Number 6. S 112-20-4088 Usual Residence of Decedent	Sex 7. Age	94 Yrs.		ours Min.	8. Date of Birth (Month, Day, Aug. 29	Year) Co	hplace (State or Foreign untry) W York
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary H sh	ţō	Maryland Montgon	erv	Gaithers	ourg				1√Yes 2□No
	h the	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	th wil	aip	301 Russell Avenu	ıe		20877		ı	United Stat	es
	r dea	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Specestican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	0	37	ecify:		Specific	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or items 23e or 28e-1 show of other than "natural" or items 23e or 28e-1 show event, it a Medical Exaciles rotal be notified at	ed b	15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occupation			16b. Kind of Business/	nite
75	in 72 n "na	Completed	(Specify only highest gr	ade completed)	(Give	kind of work done during DONOT use retired)	most of workin	9	TOD. KING OF BUSINESS	industry
212	d with giene. r that	mo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	emaker			Own Home	
ᅙ	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, tre M	BeC	17. Father's Name (First, Middle, Last)		18.7	Mother's Name	(First, Middle, M	Maiden Surname)	
/lar	Mental Mental arked c	10	Louis LaCroix			I	Ellen Ju	ıdge		
Maryland	2 sho and 1 is ms		19a. Informant's Name/Relationship (Туре, Print)	19b. Maili	ng Address (Street and N	lumber or Rural	Route Number	, City or Town, State, 2	(ip Code)
₹,	and sealth m 27		Diane E. Johnson,	Daughter	-	3 Calabash I				
ore	ges 1 of H if iten		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo	osition (Name of matory or other place)	$\mathtt{April}^{\mathtt{Da}}$	26 ,	20c. Location - City or	Town, State
Ë	tment tant:		` 4 Donation 5 Dother (Special	ý)	Memorial	matory or other place) lashington Park	1 2006		Paramus, N	ew Jersey
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Monta Important: if item 27 is marked any Injury or other treumatic a once.		21. Signatur Funeral Service Lice	2004	K.	2. Name and Address of F Ockville, Ir Ockville, Ma	nc. 300) West I	Montgomery	ineral Home/ Avenue
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	the death. Do not en e. rition	ter the mode of dying, suc	ch as cardiac or	respiratory arre	9st,	Approximate Interval Between Onset and Death Weeks
9	/Medical		resulting in death)		consequence of):					WEERS
L	Examiner		Sequentially list conditions,		shed Appe	tite				Months
X	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
1	ate be executed physicien and the burial-transit	хап	that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
8760,	be e sicien buria	icai E	T.		, ,					
687	ficate p physics fis the		•	d		_				
Вох	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
P.O.	hat the ad by detac	Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderwing cause given in F	Part I	23e Did tob	pacco use contribute to	the cause of death?
Records,	w requires t been signe should be	ted by	Osteoporosis		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	masny mg dadde green in t			s 2 XNo 3 Pro	
Rec	nysician: The law anis certificate hes be	Completed						24a. Was ar autops perform 1 Yes 2	y prior to death?	topsy findings available completion of cause of
Vital	lan: rtifica stor, p	BeC	25. Was case referred to medical			26. I	Place of Death			2010
<u>~</u>	nysic nis ce direc	ToE	examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1 🗌 Inpatier	t 2 ER/Outpatier	nt 3□ DOA Other: 4[X Nursing Hom	e 5 ☐ Reside	nce 6 Other (Spec	eify)
ion of	ding Pl		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injury at Work? M 1 TYes		3d. Describe ho	w injury occurred	
Division	in Dir	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, sti (Specify)	reet, factory, office	28	Bf. Location (Str. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Direct completely filled in b	Medical C	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of niner: On the basis of and manner state	examination and/or in	h occurred at the time, da vestigation, in my opinion	ite and place, ar , death occurred	nd due to the ca	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the Mithin Fo the	Me	29b. Signature and title of certifier			29c. License num	ber	29	9d. Date signed (Month	, Day, Year)
)	/		> (han &	Wanto.	elle	D14555		Λ.τ	oril 21, 20	006
	h		30. Name and address of person who	completed cause of de	-			A	Maryland	20886
	')		Cheryl Winchell	M.D. 192	241 Montgo	mery Village	e Avenue	e, #E10,		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	certi				

DHMH 17 Rev 1/2001

Warren Michael Koerber, Jr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1000	120	-	1	17	13	1
			6	3	11	6	1
6-	U	U	U	5 1	1.3	man of	(

		1- For State Registrar	Certific	ate of	Death		F	Reg. No.	UUU	000
Physicia Viedical Exami	an/	Decedent's Name (First, Middle, Last) Warren Michael Ko	erber J	r.			2. Date of Dea	ath Day	Year	3. Time of Death 0730 hrs
		4a. Facility Name (if not institution, give street and numb			b. City, Town, or Lo		April 22,		unty of Death	
S		1537 Bush Street 5. Social Security Number 6. Sex 7.	Age (In yrs. last bir	thday)	Baltimore City	If Under 24Hrs	R Date of B	irth/MM/DDA	VVVV 9 Ruth	nplace (State or
Funeral Director		219-92-7711 Usual Residence of Decedent	29	Yrs.	Months Days	Hours Mir	Dec.	27 , 19	76 Foreign	MArylan
any	ļ	10a. State 10b. County	10c. City, Town	or Location					Т	10d. Inside City Limits
daryland 28a-f show 1 at once.	ō		1 10	igewc		, <u>-</u>				1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 2303 Philadelphia Roa			10f. Zip Code 21040			USA	of What Coun	try?
or death wi	by Funeral	11. Marital Status 1 X Never Married 2 Married Armed Force 1 Yes 3 Widowed 4 Divorced If Yes, Give Year or Dates:	es? 2 X No	1	s Decedent of Hispa es, specify Cuban, N Yes 2 X No	Mexican, Puerto	Rican, etc.)	Spe	White, etc. cify: Wh	ite
036 ithin 72 hours afte me r than "natural" ledical Examine	Completed	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4) 10th		during mo	t's Usual Occupation ost of working life. D f-employ	O NOT use ret			of Business/Ir	•
ID 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than matic event, the Medical	Be	17. Father's Name (First, Middle, Last) Warren M. Koerber Sr			(Connie				
e, MD 2. I and 2 should Health and M. Item 27 is m.	P	19a. Informant's Name/Relationship (Type, Print) Connie Standiford / mc 20a Method of Disposition	other	230	Address (Street a Philds This is a part of the street a part of the str	elphia	Road	Edgev	r Town, State, VOOD M ation - City or	ID
Baltimore, permit. Pages I ar Department of Hee Important: If ite njury or other tr		1 Burial 2 X Cremation 3 Removal from 4 Donation 5 Other Specify:		itory or oth	Cremato	ory	^{Date} unk		imon-chy or	
Baltir permit. I Departm Importa		21. Signature of Funeral Service Licensee R. Terry Connelly (per DVR)			ame and Address o	31	00 MAc			
Physician	5 /	23a. Part I. Enter the disease, or complications that caus	sed the death. Do r	ot enter th	Connelly ne mode of dying, su	<u>Fune</u> uch as cardiac	ral Ho or respiratory ar	me ot rest, shock, d	ESSE or heart	Approximate Interval
/Medical -xaminer	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic Due to (or as a co		.on						Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	nsequence of):							
uted nd ransit	I Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a co	nsequence of):							
be execticized a sician a urial - 1	n/Medical	X unpended	item#21,23a	,27,28	Ba-f,perME,g	3855,5/10)/06 TT			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	at time of death	2 Fet	tal death 3 ner (Specify)	Ectopic pregn	ancy	23d. Da Mor	ate of delivery onth D	ay Year
O. E hat the ed by the letached	y Ph	Part II. Other significant conditions contributing to de	eath but not resulting	ng in the u	nderlying cause giv	en in Part I.				ne cause of death?
S, P	ed b									ably 4 Unknown
Division of Vital Records, P.O. rad or Attending Physician: The law requires that the ras after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed by						24a. Was auto perf 1 ✓ Yes	psy ormed?		opsy findings available ompletion of cause of S
tal Crian: certifi ector,	Be	25 Was case referred to medical examiner? Hospital: 4 122				f Death (Check		1		
of Ving Physical After this	2	1 V Yes 2 No 28a Date of 28a Date of	Injury 28b	Outpatient Time of Ir			ng Home 5		6 Other:	Scene
on c ending ath. or: Af	tion	1 Natural 5 Pending Fnd 4/2	ay Year)	7:15		s 2 X No	unk	, , ,		
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	2 Accident investigation		farm, stree	et, factory, office bui	lding, etc.	28f. Location or Town, Baltimo	(Street and 15) State) 15 re, MD	Jumber or Run 37 Bush	al Route Number, City
To the Hosy within 24 ho To the Funn	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or							
	Me	29b. Signature and title of certifier M.	16		29c. License O.C.M			29d Date	signed (Mon 2, 2006	th, Day, Year)
		30. Name and address of person who completed cause Jack Titus MD. Deputy Chief Medical			n Street, Baltir	more, MD 2	1201			
S Regis	tate	31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	-	Nº a					
DHMH 17 Rev 1/2		APR 2 6 2006	(100) 	RIGINA	100					
20015 0000	1		U	NICHA	L_					

			1 - For State Registrar	State of Mary		artment of H tificate of L		_	giene Reg. No.	16	13093
			1. Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
	Physici		Robert Kees	slec				April	2 O	Year 2006	12:45 AM
1	/Medio Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of D		4c. Count		1
2	Exami	iei	11 1 - 1	General Hosp	1.1	Colum	bia		How	vard	
۳	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 I		th	9. Birth	place (State or Foreign
	Director			M 2□F 9		Months Days	Hours N	Ain. Month, Da	1908	Cou	yland
			Usual Residence of Decedent					1 3			
	land		10a. State 10b. County	100	c. City, Town or Lo	cation					10d. Inside City Limits
	Man H	jo	MD Prince O	George's	Laurel						1 X Yes 2 No
	the 288	Jec	10e, Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	with o s	٥	114 St. Mary's Pla	200		2070	7				,.
	death with the Maryland me 23a or 28a-f ehow	Funeral Director		12. Was Decedent Ever	in IIS 13 V			/Specify Ves or No	USA	ce - Americ	can Indian,
	p ter d	'n.	MXNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	10.5.	Yes, specify Cuba	ın, Mexican, Pı	? (Specify Yes or No uerto Rican, etc.)	Bla	ck, White,	
0000	rs af	by F	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2XNo	Specify:		Specia	y: Wh:	ite
Ş	tura tura		15. Decedent's Educ		16a Deced	lent's Usual Occupa	ation		16b. Kind of B	lusinass/In	duetny
Ò	"na	Completed	(Specify only highest grade	e completed)	(Give	kind of work done of OO NOT use retired	during most of	working	TOD. Italia of E	,031110334111	dustry
Z	with there.	μď	Elementary/Secondary (0-12)	College (1-4or 5+) 4		.est	•		Cathol	ic Ch	nurah
N 0	Hygi ther int,		17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle			Idicii
and	ntal d o	Be	Frederick Keesler	_				e Boudon			
ج	d Me	Ţ.	19a. Informant's Name/Relationship (Type	V	10b Mailio	a Address (Street		r Rural Route Numb	or City or Town	Ctata 7	Codel
2	uges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If Item 27 is marked other then 'natural', or iteme 23a or 28a-f show or other treumatic event, the Mardical Examinar must be notified at	1	Monsignor Michael							707	0 0000)
— ம	teatt		20a. Method of Disposition		Ob. Place of Dispos		5 Flace	Date	20c. Location		num Ctata
0	permit. Pages 1 an Department of Heal Important: if Item 2 eny Injury or other once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cren	natory`or other plac	1		200. Eddallon	- City of To	JWII, State
аншо	men tant: jury		4 ☐ Donation 5 ☐ Other (Specify)		St. Mary'			/22/2006	Laurel		
ā	permit. Pa Departmer Important: eny Injury		21. Signature of Funeral Service License	/				Donaldson			·
	20 E = 9		James anies	han MOO!				ue, Laure		20707	/
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the ne cause on each line.	death. Do not ente	er the mode ol dyin	g, such as care	diac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Presmo	20.0						Onset and Death
	/Medical		resulting in death)	Due to (or as a co							
	Examiner		Conventingly list annulations								
Ą		ner	Sequentially list conditions, if any, leading to immediate cause. Entler Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):						
\int	cuted	Examiner	that initiated events								
Š	en ar rial-t	EX	resulting in death) Last	Due to (or as a co	nsequence of):						
200	The law requires that the death certificate be executed ste has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dicai		ı				·			
0	tifica ng ph as th	led									-
ŏ	andir use	Ž	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr 1☐Live birth 2☐		Ectopic pregnancy			23d. Da	ate of delive	ery
ם	deat d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time		Other (specify)			Me	onth	Day Year
5	t the by th ache	Physician/Me	9 Unknown	9□ Unknown							
, C	w requires that the death certific been signed by the ettending p should be detached for use as	by P	Part II. Other significant conditions con	ntributing to death but no	t resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
ĕ	quire n sig uld b	pe						_ 10	Yes 2□No	3 ☐ Prob	bably 4X Unknown
ecords,	w re	jet						24a. Was		Were auto	psy findings available
e L	sician: The law s certificete hes b irector, page 2 s	Completed							rmed?	death?	mpletion of cause of
		e C	25. Was case referred to medical				OC Plane al	1 ☐ Yes Death (Check only of		1 🗆 Yes	2LI No
	ystcian: ils certific director.	0 8	examiner?	lospital:	2 ☐ ER/Outpatien	t 3 DOA Othe	or	· · · · · · · · · · · · · · · · · · ·		(0)	
5	Phys r this rat dia	-	27. Manner of Death					ng Home 5 ☐ Resi 28d. Describe	how injury occur		y)
	Attending Physician: r death. ector: After this certific by the funeral director.	ţ	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury		k? Yes 2 □ No		, , ,		
UNISION	deat ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, larm, stre			28f. Location (Street and Numi	ber or Rura	al Route Number,
<u> </u>	after Dire	Certification;	4 ☐ Homicide determined	building, etc. (S	pecify)	201, 1201019, 011100		City or To	wn, State)		
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	C	29a. Certifier 1 ☐ Certifying Phys	sician: To the best of my	y knowledge, death	occurred at the tim	ne, date and ni	lace, and due to the	cause(s) and m	anner as s	tated.
	e Ho Fui etely	edicai	(Check only 2 Medical Examination)	ner: On the basis of exa and manner stated.	mination and/or inv	estigation, in my of	pinion, death o	occurred at the time,	date and place,	and due to	the cause(s)
	ompl	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signe	ed (Month,	Day, Year)
	- 5 - 0)/M. C	. M.)	Don	06365	53	April 20	2,700	.6
-	0		30. Name and address of person who co	mpleted cause of de-th	/Item 22al (Time	Print)	06369			, ,	
	$g_{\mathcal{C}}$		CI			r (IIII)	116	756 101	lec lan	Cal	21044 DM, 1044
	Sta	ate.	31. Date filed (Month, Day, Year)	#32. Registrar's S	Signature	d. a	1141 3	is cea	W LUTE	1010/4	314)1 NO 17
	Registi		APR 2 6 2006	Heren 1	S. 16/924						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month **Physician** Year 24, Ronald Don Kegley April 2:50 P^{M} /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 11613 34th Place Beltsville Prince George | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr 25, 19 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 236-48-6277 69 Yrs Director 1936 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show Examiner count be notified at 1 XIYes 2 ☐ No Prince George Beltsville Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ 238 11613 34th Place 20705 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Marned Baltimore, Maryland 21215-0036 6 If Yes, Give Year or Dates: 1956-58 Specify: White 1 ☐ Yes 2 🔀 No þ 3 ☐ Widowed 4 ☐ Divorced "nstural", eted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compi IDS MS Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Foreman Construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Is marked William David Kegley Anna Lee Wheelock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 I other tre Mary Kate Kegley /spouse 11613 34th Place, Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or otl once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) George Washington Cem Apr 28,06 Adelphi, Maryland 21. Signature of Funeral Service List nsee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prostatic Carcinoma with Metastasis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certiticate be executed that initiated events resulting in death) Last physicien ar Due to (or as a consequence of): Box 68760, Physician/Medical attending tor use as IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an has e 2 certificate has rector, page 2 autopsy performed? 2XX No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ۲ 1 ☐ Yes 2 X No 1 Inpatient ē 2 ER/Outpatient 3 DOA Atter thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours atter or To the Funerel Direct completely tilled in by 4 - Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D013687 April 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joselito D. Maqday, M.D. 11701 Roby Ave. Beltsville, Maryland 20705 31. Date filed (Month, Day, Year) APR 2 6 2 32. Registrar's Signature State The was 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 Date of Death Decedent's Name (First, Middle, Last): 3. Time of Death **Physician** 11. ichary APR RAUS 25 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie Baltimore Washington Medical Center Anne Arundel 5. Social Security Number If Under 1 Year tf Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 13 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours Min 10 M 2□F 83 220-12-2816 Director Germany 1922 Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d, fnside City Limits 28a-f show traumatic event, the Madical Examinar must be notified at Md Anne Arundel Annapolis 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21401 USA 865 Coachway Itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

TY Yes 2 No WWII HYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after of Heatth and Mental Hygiene. Item 27 is marked other than "natural", or Itar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +6 chemica1 business owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Schflein Heironimus Kraus 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4141 Trump Rd. Westminster, Md 21158 Ricard W. Kraus (son) or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depentment of H
Important: if itel
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 4-28-06 Sykesville, Md 4 ☐Donation 5 ☐Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Barge Haight erbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached t 1 ☐ Yes 2 Z No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 25 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation filled in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and Atle of certifier dompteted cause of death (Item 23a) (Type, Print) MILHAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 6:30 ам Kelly 21 April 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Evergreen Assisted Living Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF 215-18-6750 85 12, June 1920 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or items 23a or 28a-f ehow the Modical Examinant De notified at 1 Yes 2 No N/AMaryland Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4603 Kernwood Avenue 21212 USA death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if tiem 27 is marked other then "natural", or iten important: if tiem 27 is marked other then "natural", or iten any injury or other traumatic event, the Mudical Examina once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 1 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stenographer Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Chasney Lasko ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 Witherspoon Rd., Baltimore, ND 21229

a of Disposition (Name of Date 20c. Location - City or Town, State Peter Chasney (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4/27/06 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CNCiphakopatt **Physician** Metabolic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, rany, causing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsecuanda of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nor Conx a autopsy performed? certificate has page 1 Yes 2 No To the Hospitel or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Ceath 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [12 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month., Day, Year) 29b. Signature and title of certifier 4/24/06 100039297 13 Empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who JOPPA RD. BACT. 2314€ MO Michael 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Meil 20 00:15 AM 2006 Madaline Dora Kaiss (aka Madeline Dora Kaiss) /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City HOSPITAL ST. AUNES BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan 31, 1904 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Ballo, MD **Funeral** Days Hours 1 □ M 2√2 F 100 215-46-5568 Yrs Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "neturet", or itema 23a or 28a-f show Ite Medical Examiner roust be notified at 1 ☐ Yes 2X No Director Elkridge MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 USA 6391 RowanberryDr. #309 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. other than "neturet", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No SpecifyWhite þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5 th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fift Department of Health and Mental Hy Important: if itsm 27 is marked oth any lipiry or other traumatic avant 2008. Dora Estelle Bealefeld George Henry Deuchler 19b. Mailing Address *(Street and Number or Rural Route Number, Cit*x or Town, State, Zip Code) ep. 24 Crain HWY. S.W. Glen Burine MD 21061 19a. Informant's Name/Relationship (Type, Print) William N. Scherer Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Special) Loudon Park Cemetery 04/24/06 Baltimore MD 21229 21. Sonature Fundamentice lice 22. Name and Address of FacilityLoudon Park Funeral Home 3620 Wilkens Ave. Baltimore MD and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CEUSIS **Physician** WEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error to derrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d Date of delivery 3 DEctopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? M BRILLATION 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

EL Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MURTAR HAZMI, NO APRIL 20, 2006 Munter MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BALTIMORE MD424 MURTA 28 ST. AGNES HOSPITAL CATON AND 900 KAZMI MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

	an	1. Decedent's Name (First, Middle, Last MARION V. KI	LINKSIECK		rtificate of		2. Date of De Month	Day Year	
/Medic Examin		4a. Facility Neme (If not institution, give	a street and number)		4b. City, Town	or Location of		23, 2006 4c. County of De	4:16 A GEORGE'S
Funeral Director		5. Social Security Number 6. S 149 16 5447		ast birthday) Yrs.	If Under 1 Year Months Day	r If Under 24	Min. 8. Date of Bi	9. 8 23,1927 NE	irthplace (State or Forei Country) W YORK
or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND PRINCE 0		PER N	ARLBORO			30	10d. Inside City Lim
23a or 2 ust be ni	Funeral Directo	13924 LORD FAIRE	FAX PLACE		10f. Zip Code			10g. Citizen of What CUNITED S	Country? TATES
urel', or Items 23a or 28a-f shov I Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼ dowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 WYo If Yes, Give Year or Dates:		1 Yes 2 XX	o Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Specify:	WHITE
ene. than "naturel", he Madical Exe	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give life.	dent's Usual Occ kind of work don DO NOT use reti 'OOD SER'	e during most o	•	DEPT OF E	ŕ
it of Health and Mental Hygiene. If Item 27 is marked other than or other traumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) WALLACE BROWN				1	Name (First, Middle Y CARRING		
alth and A 27 Is ma or trauma		19a. Informant's Name/Relationship (KELLY SANDACZ (I	AUGHTER)	4609	SUTHER	LAND CI	RCLE, UPPE	per, City or Town, State, CR MARLBORO	
ment of Health lant: If Item 27 jury or other tr		20a. Method of Disposition 1 XX urial 2 □ Cremation 3 □ 4 □ Donation 5 □ 9ther (Specif	(r) TR	INITY	MEMORIA	L GARDEI		WALDORF, 1	MARYLAND
Department Important: I any injury o		21. Signatur A Funeral Service Licer	мо1461					L HOME, INC. INTON, MARY	
ysiciai Medical	. Vi	23a. Party. Enter the disease, or com- strock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on the line.	n. Do not en	er the mode of d	ying, such as ca	ardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
caminer	er	Conventially list conditions	b. Inofer	N	Chas	me	OF THE		
nysician and he burial-transit	Examin	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due or as a consequence.	uence of):	reme	6-76	fere	E	
y the attending physician and iched for use as the burial-transit	dicai Examin	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (uf as a consequence) Due or as a consequence) d. 23c. If yes, outcome of pregnance 1 Live birth 2 Fetal 4 Pregnant at time of de	ncy death 3[DEctopic pregnar	lo glo	for the second	23d. Date of d Month	elivery Day Year
igned by the attending p be detached for use as	by Physician/Medical Examin	if any, leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{TNQ} \)	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	ncy death 35 eath 55	Other (specify)			Month tobacco use contribute	Day Year to the cause of death?
ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Medical Examin	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	ncy death 35 eath 55	Other (specify)	given in Part I.	24a. Was auto penti 1 □ Yes	Month tobacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2No 1 Yes	Day Year to the cause of death? Probably 470Unkno autopsy findings availa
lter this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical Examin	is any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	ncy death 35 eath 55	Other (specify) Indertying cause of the second sec	given in Part I. 26. Place o	24a. Was auto perfit 1 Yes 1 Death Check only ing Home 5 Resi	Month tobacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2No 1 Yes	Day Year to the cause of death? Probably 475Unkno autopsy findings availa completion of cause as 2 \(\sqrt{No} \)
lter this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Tho 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 Tho 25. Was case referred to medical examiner? 1 Yes 2 Tho 27. Manper of Death	23c. If yes, outcome of pregna 1	ncy death 3 [ath 5 [witting in the u	other (specify) nderlying cause of the second of the seco	26. Place o other: 4 \(\) Nurs ury at ork? \(\) Yes 2 \(\) No	24a. Was auto perfit 1 Yes f Death **Check only ing Home 5 Resident Reside	Month tobacco use contribute Yes 2 No 3 F an proper death? 24b. Were a prior to death? 1 Yes one) idence 6 Other (Sp how injury occurred	Day Year to the cause of death? Probably 4 2 Unkno autopsy findings availa completion of cause of as 2 No
lter this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes Yes	23c. If yes, outcome of pregna 1	ncy death 3 [sath 5 [witting in the u	other (specify) nderlying cause of the second of the seco	26. Place o other: 4 Nursury at ork? Yes 2 No	24a. Was auto perfit 1	Month tobacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2 No 1 Ye one) idence 6 Other (Sp how injury occurred	Day Year to the cause of death? Probably 47 Unkno autopsy findings availa o completion of cause of secify) Pural Route Number,
r this certificate has been signed by the attending p ral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical Examin	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 27. Manner of Death 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Medical Exam	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown ontributing to death but not result Hospital: 1 □ Invatient 2 □ 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hobuilding, etc. (Specify	ncy death 3 [sath 5 [witting in the u	other (specify) nderlying cause of the second of the seco	26. Place o other: 4 Nursury at ork? Yes 2 No	24a. Was auto perfit 1	Month tobacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2 No 1 Ye one) idence 6 Other (Sp how injury occurred	Day Year to the cause of death? Probably 4 Unknot autopsy findings availa completion of cause as 2 No Pecify) Rural Route Number, as etatod.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		12		Siai	e or ivia	aryiand /		rtment of F tificate of t		Mental Hy	giene Reg. No.	96	13099
Ħ	Physicia	n.	1. Decedent's Name (First, Mic							2. Date of De Month	ath Day	Year	3. Time of Death
-	/Medic		CHRISTINE							APRIL	22 20	006	4:10 AM
A. A.	Examin	er	4a Fecility Name (If not institut		d number)			1		r Location of Death	4c. County	of Death	
			Sacred Heart		1 = .			It I lades 4 Vans	Hyatts				orge's
	Funeral Director		5. Sociel Security Number 269-07-0955	6. Sex 1 ☐ M 2X		e (In yrs. last b	Yrs.	Months Days	Hours Mir		th ly, Year) 1 1914	9. Birthpl Count Tenr	lece (State or Foreign try) NESSEE
	pue 👔		Usual Residence of Decedent 10a. Stete 10b. Cour	nty		10c. City, To	wn or Loc	ation				10	Od. Inside City Limits
	e Maryl	ctor		Arundel		Lauı							1 ☐ Yes 2 ☒ No
	# 9 ₩		10e. Street end Number					10f. Zip Code			10g. Citizen of V	Vhet Count	try?
	ath w	a	3523 Forest H					207			US	A	
20	hours efter death with the Marylend turel', or items 23s or 28s-f show al Exarciner mant be notified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ M 3℃Widowed 4 ☐ Divorce	arried Arme	ed Forces? ∕es 2¥∑1 s, Give	Ever in U,S. No			lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)	14. Rac Blac Specify	e - America ok, White, e	etc.
Ş	hour	8		ent's Educetion	or Dates:	16	a Decede	ent's Usual Occup	ation		16b. Kind of Bu		
15	in 72 I nat	Set	(Specify only high	nest grade comple			(Give k	ind of work done of NOT use retired	during most of wo	orking	100. Kind of bt	isiness/ind	ustry
Maryland 21215-0020	filed within 7 Hygiene. After than "r ent, the Med	Completed by	Elementary/Secondary (0-12 12th		ge (1-4or 5 Ø	i+)		maker	•		Own	Home	<u> </u>
Þ	be filed htal Hygic od other event, ti	Bec	17. Father's Neme (First, Middl	e, Last)	-	'			18. Mother's Na	ame (First, Middle,	Maiden Sumam	ю)	
/lai	0 2 2 0	2	Leonard Cof	felt					011:	ie Barne:	5		
lan	d 2 shoul th end Me 7 le mart traumati		19a. Informant's Name/Relatio	nship <i>(Type, Print</i>)	19	b. Mailing	Address (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zip	Code)
≥,	サード		Pat Kirkpatri	ck/Daugh	ter				laven Dr:	ive, Lau	rel, MD	2072	24
ore	of the second		20a. Method of Disposition 1 Burial 2 □ Cremation	n 3 □Removali	rom State	20b. Place cemet	of Dispos ery, crem	ition (Name of atory or other plac	ce)	Date	20c. Location -	City or Tox	wn, State
ΕÏ	nit. Peges entment of ortent: If it injury or o		4 ☐ Donation 5 ☐ Other	(Specify)	TOTAL CITATO	Gate				4/26/06			
Baltimore,	permit. Peg Depertment Important: I any Injury o		21 Signature of Funeral Service	e Licensee						Donaldsor			
_	00 = 6 a		tance	ex/h	A A	01103				ue, Laure		20707	,
\. \.	Physician /Medical Examiner		23a. Part1. Engr the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in deeth)	or complications t ist only one cause	a		540	n Hel			rrest,		Approximate Interval Between Onset and Death
30x 68760, <	ificete be g physicia es the bu	Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b c		Due to (or as a		,					
Ö.	he ett		Part II. Other significant condi	tions contributing	to death bu	ut not resulting	in the und	derlying cause give	en in Part I.	23b. Did	obacco use cor	tribute to	the cause of death?
), P.O	s that the ned by t e detech	y Phy	Chronie a	trial	fit	n'llah	ion	, Urin.	ary	1 🗆	Yes 2□ No	3 Prob	ably 4 Unknown
Division of Vital Records, P.O. Box	5 0 N	Completed by	Chronic a	ction	o d	emen	tia	, hypoT	ayroid	24a. Was perfo	an autopsy med?	ava	re autopsy findings ilable prior to npletion of cause leath?
<u>ح</u>	sician: The lew s certificate has b director, pege 2 s	5								101	res 2X(Nu	1 🗆	Yes 2□ No
/ita	clan: ertific sctor,	8 P	25. Was case referred to medic examiner?	+						eath (Check only o			
J	hysic this c	2	1 Yes 2 No		1 🗆 Inpatie			-	4/L) Nursing	Home 5 Resid)
Ä	After funer	<u>ë</u>	27. Manner of Death Natural 5 ☐ Penc	ding (ete of Injur Month, Day	Yea <i>r)</i> 285.	Time of Injury	28c. Injun Worl	k?	28d. Describe I	now injury occurr	ed	
Division	To the Hospital or Attanding Physician: The ke within 24 hours efter deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, pege.	Certification:	3 Suicide 6 Coul	mined 286.	Place of Injudual		arm, stre	et, factory, office	Yes 2□No	28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura/	Route Number,
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one)	al Examiner: On t	the best one basis of manner sta	examination a	e, death ond/or inve	occurred at the timestigation, in my of	ne, date and plac pinion, death occ	e, and due to the surred at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)
	To the Vithin To the	_	29b. Signature and title of certif	ier	-			29c. License	9 number 3/2/		29d. Date signed		lay, Year)
	^	1		odly, n							04/24	100	
	3		30. Name end address of person NURUL CHOW	n who completed	cause of de	eath (Item 23e)	(Type, P	rint) ORIVE	BURT	ONSVILL.	E, MT)	208	66
	Stat		31. Dete filed (Month, Day, Yea	r) @ 3	2. Registre	er's Signeture	1 .6	,,,,,,,			, , ,	-	
	Registra	-	31. Dete filed (Month, Day, Yea APR 2 6 21	006	PAR CO I	S. As	34/1	!					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 5:36p Edmond Francis Lafferty 24 2006 April /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1√2 M 2□ F Yrs. 219-18-6561 Director July 4 1923 Md Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ir then "netural", or Items 23a or 28a-f show the Medical Examiner must be notified at Md Baltimore Baltimore 1 ☐ Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8011 Woodgate Ct. Apt A 21244 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 TYes 2 No WWII I Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) tool and dye College (1-4or 5+) machinest h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Edmond Lafferty Wihelmana Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other trav QDCS. Elizabeth Lafferty (spouse) 8011 Woodgate Ct. Apt. A, Baltimore, Md 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 4-28-06 Sykesville, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Parge Hargert Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardlowsullar ARTORIOSCIELLE **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? evelative 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? Would 24a. Was an performed? 1 ☐ Yes 2 1 No 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ② ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To After the 27. Manner of Death 1 Di Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No f Director: 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name are address of person who completed cause of death (Item 23a) (Type, Print) 1000 LIBERT RD ELDOPS CA ATRICK Silte 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/200

ORIGINAL

1	0	- 1	\cap	-1
ă.	1		111	-1
	3	- 9	1/	- 6

29d. Date signed (Month, Day, Year)

April 26, 2006

State of Maryland / Department of Health and Mental Hygiene U U 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 19, Day 2006 Year Physician OSWALD LOCKARD, SR. 11:15 AM /Medical 4a. Facility Name (If not institution, give street and number)

24274 Horse Shoe Road 4b. City, Town, or Location of Death 4c. County of Death Examiner Clements St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Sta County)

July 23, 1931

Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. XXM 2□F 230 28 0850 74 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at Prince George's Maryland | Clinton 1 ☐ Yes 2 XXo Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5506 San Juan Drive 20735 United States Funera Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 **V**es 2 □ No If **Yes**, Give Year or Dates: 1952-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XX Specify: Specify: þ 1960 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder Stee1 12 permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 ie marked othe any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0swa1d Lockard Vaughnie Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Jean Lockard (wife) 5506 San Juan Drive, Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee Crematory April 24, 2006 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Juneral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Colorectal Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) cal Physician/Medi 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Be ဥ

Box 68760. Records, P.O. Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

			-	Α.
			24a. Was an autopsy performed? 1 ☐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medic	al	26. Place of D	Death (Check only one)	
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA Other: 4 Nursing	4 Nursing Home 5 Residence 6 MOther (Specify) QOIL :	
Z/NOCIGORI	tigation		28d. Describe how injury	y occurred House
3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	office 28f. Location (Street and Number of City or Town, State)	
29a. Certifier (Check only one) Certify	ing Physicien: To the best of my knowledge, du if Examiner: On the basis of examination and/o- and manner stated.	eath occurred at the time, date and pla r investigation, in my opinion, death oc	ace, and due to the cause(s) courred at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

D 0062288

w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kikhil Uppal, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636

State Registrar

Certification:

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 6 2006 APR 2

		-	For State Registrar	State of M	_	epartment of F Certificate of			giene 0 0 6	13102
ş.,	Dhusisi	7.95	1. Decedent's Name (First, Middle,	1				2. Date of De Month		3. Time of Death
K.	Physicia /Medic	al -	Dertha .	Lel			- 1 1 D -		13, 2006 4c. County of	1:00 P ^M
7	Examin	er	4a. Facility Name (If not institution,				or Location of De	atn		
	Funeral	(C.)	Anne Arundel Me 5. Social Security Number	6. Sex 7. A	ge (In yrs. last birtho		napolis If Under 24 H Hours Mi			Arundel Birthplace (State or Foreign Country)
. Rej	Director		149-16-3142 Usual Residence of Decedent	1□M 2√2F	93 ^{Yr}	3. Worth's Days	Tiodis	April	14,1912 E	Florida
	and ow		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Mary a-f sh	tor	New Monmou	th	Neptune					1 ☐ Yes 2 🔀 No
	or 284	Oirec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	s 23a	rai	5 Pharo Street	10 Was Decedent	Ever in II S	07753	dispanie Origin?	(Specify Ves or N	United St	ates American Indian,
10	fter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces ad 1 Tyes 2 Ty		13. Was Decedent of I If Yes, specify Cub		erto Rican, etc.)	Black,	White, etc. African
036	72 hours after death with the Maryland natural; or Nems 23s or 28s-f show Jissi Exacilist must be notified at	Ď	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	American
15-0	"natu	Completed	15. Decedent's (Specify only highest		(6	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	during most of v	vorking	16b. Kind of Busin	ness/Industry
121	within ene. then	дшс	Elementary/Secondary (0-12) 12	College (1-4or	5+)	iousekeeper			Home	
ק	be filed within 72 hours after death with the Marylan ital Hygliene. Ind other than "natural; or items 23s or 28s-f show other than "natural; or its medical Experience ovent; it a Medical Experience or collined at	BeC	17. Father's Name (First, Middle, L	ast)				lame (First, Middle	, Maiden Sumame)	
ylar	should be nd Mental marked o	ToE	Clayton William					Onie Ruis		
Maryland 21215-0036	ges 1 and 2 should it of Health and Mer if Item 27 le marke or other traumatic		19a. Informant's Name/Relationsh	are on the real sections		lailing Address (Stree				
	Heali Heali tem 2		Bertha Coles, D 20a. Method of Disposition	3.54	20h Blace of C	Pharo Street isposition (Name of		Data	200 Location Ci-	br or Town Ctate
E	Pages nent of int: If Its iry or o		1 😾 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Brig. Ge	crematory or other plan. William C.	Doyle 0	4/21/06	Wrightstow	n, New Jersey
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signatura Funda I Sofvide L	icensee	vecerans	Campania Vd Addr	ess of Facility	Harman	Funeral	Service
37	40 E # 9		23a. Part1. Enter the disease, or o	amplications that cause	M01113	7221 Gray	burn Dri	ve Glen	Burnie,	MD 21061 Approximate
	Physician		shock, or heart tailure. List of the disease or condition resulting in death)	a	u gestive	heart	/			Interval Between Onset and Death
	/Medical Examiner		resulting in douting	Due to (or a	s Consequence of	temosis				Months
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of	:				
	cate be executed physicien and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	be exicien a	icai E	Tooling II. dodney allow	Due to (or a	s a consequence of					
687	ficate p phys			d						
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Petal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ey		23d. Date o Month	
	w requires that been signed b should be deta	þ	Part II. Other significant condition		but not resulting in t	he underlying cause g	ven in Part I.			ute to the cause of death?
Vital Records,	The law recate has been page 2 sho	Completed	/	U				24a. Wa auto perf 1 ☐ Yes	opsy pric	ore autopsy findings available or to completion of cause of ath?
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			hor	Death (Check only		(0
ō	g Phys ar this eral di	n: To	1 ☐ Yes 2 Ø No 27. Manner of Death	28a. Date of In	jury 28b. Tii	ne of 28c. Inju	4 🗀 Nursin		how injury occurred	
ion	ttending Ph death. ctor: After th y the funeral	atio	1. ✓ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	oay rear) in		ork?]Yes 2 □No			
Division	tal or Atter de s after de bl Directo	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Place of I	njury - At home, farr etc. <i>(Specify)</i>	n, street, factory, office		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C		g Physician: To the bes Examiner: On the basis and manner:	of examination and					
	To t To t	Ž	29b. Signature and title of certifier	en SRy	Sa MO	29c. Licer	ose number		29d. Date signed ((Month, Day, Year) 3-2006
	d		30. Name and address of person of the control of th	who completed cause of	death (Item 23a) (T	ype, Print) Medical	Parku	ay, An	n apolas	3-2006 MO 2146)
*	St. Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 6		strar's Signature	books			/	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MONRIL Day. 2886 7:02P **Physician** Lates Elizabeth /Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Center Saint Joseph Medical 8. Date of Birth (Month, Day, Year) June 10, 1937 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 💢 F 68 Yrs. Maryland 214-64-0389 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ehow. Itam 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Edgemere Baltimore Maryland Directo the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21219 USA 2854A Lodge Farm Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White à 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 ie marked other than "n eny injury or other traumatic event, Iba Madi 2016. Elementary/Secondary (0-12) College (1-4or 5+) Own Home **Housewife** 10 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Doud Maymard Auten ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 617 Flintlock Drive, Belair, Maryland 21015 Mary M. Ziethen sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 22. 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. Rosedale, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY ARREST Pnysician /Medical Due to (or as a consequence of): YEAR Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examiner use as the burial-transit 2 DAYS The law requires that the death certificate be executed CHRONIC VENTILATORY FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 SEPTIC SHOCK Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 19 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) cete has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, TRANSVERSE MYELITIS WITH QUADRIPLEGIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(\sum \) No 26. Place of Death (Check only one funeral director. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours at To the Funeral D completely filled i the Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D35453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 TOWSON, 7505 OSLER DRIVE, SUITE 409, INDA BARR. 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Health and Men	tal Hygier	ne	
		1	1 - State Registra Amend Item #28b Per M 1. Decedent's Name (First, Middle, Last)	E G854 499	26/00et910f		Reg.	No. 006	13104
	Physic	an	1					Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (It dot institution, give street and number)		4b. City, Town, o	or Location of Death)५ ७३	4c. County of Death	7245™
1			University of majuland	martical 1	ntr.	Baltimor		N/A	
	Funeral Director			(In yrs. last birthda 77 Yrs.	y) If Under 1 Year Months Days	Hours Min.	Date of Birth Month, Day, Yea C. 8, 1	9. Birthp Coun 928 Chir	lace (State or Foreign try)
	12		Usual Residence of Decedent			De	C. 0, 1	928 Chir	la
	death with the Maryland ma 23a or 28a-f show rmust be notified at	_	10a. State 10b. County	10c. City, Town or	Location			1	0d. Inside City Limits
	Ba-f	Director	Maryland Baltimore	Baltimo					1 ☐ Yes 2 X No
	ath with t	ä	10e. Street and Number 618 Walker Avenue		10f. Zip Code	1010	10g.	Citizen of What Coun	try?
	death w	Funeral	11. Marital Status 12. Was Decedent B	Ever in U.S. 13		1212 fispanic Origin? (Specify	Yes or No-	U.S.A.	an Indian
36	or ite		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xh	lo	If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	dispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	n, etc.)	Black, White,	etc.
21215-0036	"naturel",	ed by	3 ☐ Widowed 4 N Divorced Year or Dates: 15. Decedent's Education	162 Dos	edent's Usual Occup		101		nese
215		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Giv	re kind of work done DO NOT use retired	during most of working	166.	. Kind of Business/Inc	lustry
21	giene grene er the	E O	4 years	+)	Homemak	er	(Own Home	
pu	be file d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fir	st, Middle, Maid	len Sumame)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	ို	Jan Leung 19a. Informant's Name/Relationship (Type, Print)	105.44		Hing	Chiu		
<u>N</u>	od 2 si Ith an 27 is r		Kellie Hom (daughter)		Walker Av	and Number or Rural Ro			
re,	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If Item 27 is marked other then or other traumatic event, the Me		20a. Method of Disposition	20b. Place of Disp		Date		aryland 21 Location - City or To	
<u>E</u>	nit. Page eartment c ortant: If injury or		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	unt Crema	1	06 Ba	altimore,	Marvland
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licensee	M	22. Name and Addre	ss of Facility iedefeld Fur	neral Ho	ome The	Last y Lastin
	40 5 0 0		Teory & Chan		DOUU_YORK	Road Balt	imore N	Maryland 2	1212
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final	e.	nter the mode of dyin	ig, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a	consequence of):	Lementer	nic	4		5 hours
	Examiner		Sequentially list conditions b. Incre	ased in	Macrani	al pressu	rel		
XX	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	D	/	Λ		
4	icate be executed physiclen and s the burial-transit	Examiner	triat initiated events	consequence of):	10550	Controling ATROVED) LOAL EXA	MINER	
8760,	ysicler ne buri	dicai E	d			TION AR ROVED	NEDIONE		
9		• • ·	IF FEMALE:			CERTIFIC			
Вох	ath ce	lan/I	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3	□Ectopic pregnancy	, /		23d. Date of deliver	y Day Year
P.O.	The law requires that the death certificate has been signed by the attending fage 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ime of death 5	Other (specify)			WORLD	Day Feat
	es that igned b be deta	y Pt	Part II. Other significant conditions contributing to death bu	t not resulting in the	underlying cause give	en in Part I.	23e. Did tobacco	o use contribute to the	cause of death?
of Vital Records,	w require been sig should b	Completed by	AMYOTROPHIL LATERAL:	SCLERUSI	5		1 ☐ Yes	2 ☐No 3 ☐ Proba	bly 4 □Unknown
ecc	has be pe 2 sh	nple					24a. Was an autopsy	24b. Were autop	sy findings available
al H		S.				1	performed? ☐ Yes 2 🗹	death?	
Vita	Physician: Th r this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ res 2 ☐ No Hospital:		Othi	26. Place of Death /Ch	- 18 7 7		
o	ding Physician: n. After this certific funeral director,	\vdash	27. Manner of Death 28a. Date of Injun	28b. Time	of 28c. Injun	/ at 28d. I	5 Residence Describe how in		
ioi	anding Frath.	atio	1 □Natural 5 □ Pending (Month, Day) 2 ☑ Accident investigation 4 23	1000	pgn World		messe	el fall fro	m standin
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc.	ry - At home, farm, s (Specify)	treet, factory, office	28f. L	ocation (Street a	and Number or Rural	Route Number
	pital ours al		29a. Certifier 1 Sertifying Physician: To the best of	lone		i	15 LX	ekel Ave	2 21212
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or i	th occurred at the tim nvestigation, in my of	ne, date and place, and d pinion, death occurred at	ue to the cause the time, date a	(s) and manner as sta nd place, and due to	ted. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License	e number	29d. D	ate signed (Month, D	ay, Year)
	1		H	MAD	16	536	AP	RIL 23,	2006
	2		30. Name and address of person who completed cause of de						
	Sta	to	31. Date filed (Month, Day, Yeld) 38 Shistral	22 S. ('s Signature	reene Str	eet Baltim	ore, Ma	ryland 212	.01
	Registr	-	APR 2 6 2005	A GO	sales)				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician 6:30 PM 2006 SEROME FRANKLIN MONROE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA SINAL HOSPITAL BALTIMORE If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Hours Months 1**X** M 2 □ F Director 218-44. 4397 12 - 20 - 1945 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Int: If Hem 27 is marked other then "natural", or items 23a or 28e-1 show 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State f Health and Mental Hygiene. Item 27 Is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at 1 Yes 2 No NIA Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code NELSON! 21215 5419 AVE USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 图 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LOADER INSULATION COMPANY 12 TH GRADE NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JEROME MONROE RUTH BAYLIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COCKEYSVILLE , MD 21030
Date 20c, Location City 19a. Informant's Name/Relationship (Type, Print) #E 6 BREXY HILL CT. ANNA MONROE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H important: If Ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04.22.06 RANDAUSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) KING PARK 22. Name and Address of Facility
VAUGHN C- GREENE FUNERAL SERVICE
5151 BAUTO. NATE PIKE, BAUTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit R CINO that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the e 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Z No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy rmed? 2 (█,No 1 ☐ Yes the Hospital or Attending Physicien: After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Medical Certification: To 1 Tes 2 No 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natoral 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23a) (Type, Print) (. 30. Name and address of person who completed cause of death (Item 00 P 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

06-02771 William Moody

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

villam Woody		1- For State Crivial yiand / Department of Fleath and Wentai Hygiene Certificate of Death Reg. No. 2 0 0 5 3 1 (of the State of th			
Physicia Medical Exami	.111/4	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day April 24, 2006 3. Time of Death 0536 hrs				
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death				
Funeral		5. Social Security Number 10 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or				
Director		1 M 2 F 23 Yrs. Months Days Hours Min. 12 · 14 · 1982 Foreign Country) MD				
any	-	Usual Residence of Decedent 10a. State	nits			
*	ē	MD NA BALTIMORE 1 K Yes 2	No			
15-0036 filed within 72 hours after death with the Maryland Hygiene of other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 367 WABASH AVENUE 21215 USA				
ath with items 23	neral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, 15. White, etc.				
after de al", or i	by Fu	3 Widowed 4 Divorced If Yes 2 K No specify: Specify: Specify: BLACK				
2 hours "natur	eted b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				
5-0036 led within 72 hours a Hygiene other than "natura the Medical Examin	Completed	11 TH GRADE NA CLERK STATE OF MD				
21215-0036 buld be filed within 7 Mental Hygiene marked other than cevent, the Medica	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DEBORAH SAMPLE				
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental t: If item 27 is marked other traumatic event,	٤	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ESSIE L. MOODY, JR 3101 CLIFTMONT AVE., BATTO. MD 21213	Ī			
re, MD 1 and 2 sho 1 Health and 7 item 27 is	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Cremation 3 Removal from State crematory or other place) 20c. Location - City or Town, State	\neg			
.⊑ ⊡ ≘ ⊑ .		4 Donation 5 Other Specify. KING PARK 04.29.06 RANDAUSTOWN, MD				
Balt permit Depart Import		21. Sunature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A peroximate Inter				
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Acute pneumonia Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	_			
_	Examiner	cause. Enter Underlying Cause (Underloos of Highly that Hilliand events resulting in death) Last Due to (or as a consequence of):				
recuted n and - transit		dd	_			
760, icate be e physicial the burial	Medical	IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery				
Box 687 death certific the attending p	sician/	23b Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)				
P.O. Boy that the death ned by the att	Physi	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death?	- 10			
, PO.	Š	þ	ģ	ģ	Diabetes mellitus 1	
cords, aw requirents been as been a	Completed	24a Was an autopsy findings availa autopsy prior to completion of cause of				
Vital Rec ysician: The li his certificate h director, page	Com	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)	_			
Vital hysician this cert	To Be	examiner? 1 ✓ Yes 2 No Hospital 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other, Nursing Home 5 Residence 6 Other.				
on of anding Pt. th.	i.i	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No				
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Corr Town, State)	ity			
Divisior Hospital or Attent 24 hours after death Funeral Director:		4 Homicide (Specify) 29a. Certifier Continued (Specify)	_ ;			
Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 24, 2006				
		30. Name and address of person who completed cause of death (Item 23a)				
	tate	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regis		RITATA DE PERIODE AND AN				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Baby Girl Miles 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2♥F Yrs. Director none 17, 2006 Maryland Apr Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits worde I r then "naturel", or iteme 23a or 28a-f ehor It e Medical Exaction must be notified at 1√ Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1608 Gorsuch Road 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No ff Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) other then none none Pages 1 and 2 should be filed w itment of Health and Mental Hygie rtant: If Item 27 is marked other it jury or other traumatic event, I. none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tamara S. Miles William Terry Pinkney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 600 N. Wolfe Street Baltimore, MD 21287 Johns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☑Other (Specify) in stalte 21. Sign ture Funeral Serve Licensee S. Wade, Airector State Anatomy Bard 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Thra 58 km **Physician** maturity /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai use as attending p fF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital : After this certification of funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar

eterson

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



OT PETERSON

completed cause of death (Item 23a) (Type, Print)

			State of Marylan	nd / Depa		ealth and M	lental Hyg		6 13108
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day	Year 3. Time of Death
	/Medio Examir		Lloyd Morse 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Apr 16,		3:03 a ^M
	Exami	iei	Future Care Irvington		Baltimor	e			,
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	**	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		214-56-5415 54	Yrs.			May 18,		Maryland
	show		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits
- \	Mary a-f sh	tor	MD B.	altimor	* 0				1½TYes 2☐No
X	th the or 28,	Director	10e. Street and Number	<u>ur crinoi</u>	10f. Zip Code		1	0g. Citizen of	What Country?
7	be filed within 72 hours after death with the Maryland ital Hygiene. In the matural, or Items 23a or 28a-f show of other than "natural," or Items 23a or 28a-f show event. It is Medical Exertified at	ral	22 S. Athol Avenue		21229			USA	
2	er de Items	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American Indian, ick, White, etc.
38	urs att	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	☐ Yes 2⊠ No	Specify:		Specia	^{fy:} black
5-06	within 72 hours atter ane. than "natural", or Ite	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	tion	na	16b. Kind of B	Jusiness/Industry
\sim 22	ithin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done di OO NDT use retired)		, ig		
12	led w lygier her th		12 2 17. Father's Name (First, Middle, Last)	репе	fits Coor		/First Middle A	Veriz	
and	d be find the find the find the find of the find of the find of the find th	Be	Lloyd C. Morse, Sr.			18. Mother's Name		лаюн Битаг	πθ)
SE	should nd Men marke imatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	Agnes May	VS Il Route Number,	City or Town	, State, Zip Code)
\(\int_{i}\) \(\begin{array}{c} \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	and 2.		Shawny Morse/daughter		Dudley A				
ore,	of Her		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Place of Dispos	sition (Name of natory or other place				- City or Town, State
₩.E	Page ment ant: H		'4 □Donation 5 ☑Other (Specify) in state						
$\mathcal{H}_{\mathcal{O}}$ Baltimor	permit. Pages 1 and 2 should be filed withir Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, If a Na. Once.		21. Signature Huneral Sence Licensee Ronald S. Wad Virector	r St	Name and Address ate Anato L'Dimore	my Board	655 W.	Baltim	ore Street
	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, of complications that caused the death shack, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coupertially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	th. Do not enter United the property of the p	er the mode of dying every A	, such as cardiac o	4		Approximate Interval Between Onset and Death
68760,	ficate be executed physicien and is the burial-transit	edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C	uence of):					
Division of Vital Records, P.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	il death 3 □	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
rds, F	w requires tha been signed should be del	ed by P	Part II. Other significant conditions contributing to death but not res	4	derlying cause given				tribute to the cause of death? 3 □ Probably 4 ☑Unknown
al Reco	: The law re cate has bee , page 2 sho	Completed	Hypothyroidism,	Oster	varthe	ilis	24a. Was ar autops perform	ned?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vit	yaician: Th is certiticate director, pag	Be	25. Was case referred to medical examiner?		Other	26. Place of Death			
ion of	nding Physath. r: Atter this e funeral di	atlon; To	1 Yes 2 No	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 X Nursing Hor	ne 5∐ Reside 28d. Describe ho		
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At ht building, etc. (Specification of the suit o	(y) 		1	City or Town	, State)	per or Rural Route Number,
	he Hosp in 24 hou he Funei pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my opi	a, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and mate and place,	anner as stated. and due to the cause(s)
	Mithi To t	Σ	29b. Signature and title of certifier		29c. License				d (Month, Day, Year)
			> & PHYSICAAN			7543		4-19	
			30. Name and address of person who completed cause of death (Item	n 23a) (Type, F	Print)	FCT	011	1 1 122 111	26, MN 21923
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signa	Hure And	white	3/1	124-6	1100	
	Registr		APR 2 6 2006	To proper to					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 21, 2006 5:49PM March Roberta McBride /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5026 Palmer Avenue Hours Min. 8. Date of Birth (Month Day, Year) Oct 25, 1959 If Under 1 Year 5. Social Security NumbelUNK 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🛛 F Yrs. 46 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow other traumatic event, the Medical Examiner must be retilied at 1√2 Yes 2 □ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with or items 23a or 5026 Palmer Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. unk 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specity: Specify b1ack þ 3 - Widowed 4 - Divorced "natural" Completed unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. College (1-4or 5+) Elementary/Secondary (0-12) unk unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Baltimore City Police Dept 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 🛛 Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Signature of Euneral Service Ronal L 7000 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) nero /Medical Due to (or as a consequence of) **Examiner** 10 en Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequer ce o Examiner or Attending Physician: The law requires that the death certificate be executed 0 burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical 9 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, pe 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Whas an autopsy performed 22 No 2 X No 1 Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 3□ DOA Medical Certification: To 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) regos cas 830 32. Registrar's Signature 31. Date filed (Month Day, Year) State Registrar 6 2006

		For State Registrar	State of Maryla			f Health and lof Death		giene 0 0	6	3 10
Dhusisis		1. Decedent's Name (First, Middle, La					2. Date of Dea		Year	3. Time of Death
Physicia /Medica		Vicki L	. Merritt				April	21 ^{ay} 200		8:30a M
Examine	er	4a. Facility Name (If not institution, giv				n, or Location of Deat	h	4c. County		
		Gilchrist Cent		land block down	TOWS		0. D-45 -4 Birt	Balti		
Funeral Director			1 ☐ M 2 ☐ F	5. last birthday) 52 Yrs.		ys Hours Min.	8. Date of Birth (Month, Da) Dec. 11	1953	MAT	lace (State or Foreign
		Usual Residence of Decedent		J 2	l		200	/ / 200		
how		10a. State 10b. County MD Baltin		ity, Town or Lo	cation le Riv				1	0d. Inside City Limits
Ba-f e	cto		more	MIGG						1 ☐ Yes 2 ☐ No
th with th	al Director	10e. Street and Number 1423 Third Roa	ad		10f. Zip Coo 212			10g. Citizen of W USA	hat Cour	ntry?
ams arm	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)		- Americ	an Indian, etc.
safte or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No		1 🗆 Yes 2 🗖			Specify	7.71-	ite
hours a hours a levan	g pe	3 ☐ Widowed 4X Divorced 15. Decedent's E	Year or Dates:	16a Docco	dent's Usual Oc	counstion		16b. Kind of Bu		dunta
n 72 an c	Completed	(Specify only highest gr	ade completed)	(Give	kind of work do DO NOT use re	one during most of wor tired)	rking	Dolla		•
with right	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)		e MAna			DOTTAL		66
yidilia buld be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last Harry M. Foo		'			ne (First, Middle, ne E. K		3)	
shoul nd Man	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Str	reet and Number or Ru	ıral Route Numbe	r, City or Town,	State, Zip	Code)
ind 2 alth a 27 is		James Merritt	/son	687	Kitte	endale Ci	rcle Ba	ltimor	e MI)
Daillillore, IMaryialla Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show eny Injury or other traumatic event. The Medical Examination must be rotified at page.		20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	Place of Dispo cemetery, cred IOLLY		emetery	Date 4/25/06	20c. Location - 6 Baltir	City or To	e MD
permit. Pages Department of Important: If It eny Injury or o		21. Sign three of Funeral Service Lice	nsee .	22	Name and Action	ddress of Facility 3 (00 Mace	Ave. I	Balt	o. MD 21221
	1	23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the	1						Approximate Interval Between
Physician		Immediate Cause (Final	a. Breast	PAINCAN					1	Onset and Death
/Medical	-	disease or condition resulting in death)	Due to (or as a conse	equence of):						yens.
Examiner		Conventially list conditions	b							
- B =	ner	Sequentially list conditions, it any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Oue to (or se a cone	quanta of):						
outed ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
in an a	ŭ	resulting in death) Last	Due to (or as a conse	quence of):						
cate be executed physician and the burial-transit	dical		d							
certificate be executed right physician and use as the burial-transit	hysician/Me	IF FEMALE:	23c. If yes, outcome of preg	nancy				201.0		·
Bath attentor for u	lan	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 Live birth 2 Fe	tal death 3	Ectopic pregna Other (specify			23d. Date Mor		Day Year
the d	iysk	1 ☐ Yes 2 M No 9 ☐ Unknown	9 Unknown	doatii 5	2 Ottier (specin)	/				
es tha igned be det	by P	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause	given in Part I.			bute to th	ne cause of death?
v requir been si should	etec							-		, 7
The la	Completed						24a. Was a autop perfor	sy p med? d	fere auto rior to cor eath? □ Yes	psy findings avaitable impletion of cause of
certifica ector, p	Be	25. Was case referred to medical examiner?	l lanatati				ath (Check only or	ne)		^
Physic this c	P	1 Yes 2 XNo		ER/Outpatier			lome 5 Resid			nhospice
ding f	0	27. Manner of Death ↑★○Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work? 1 □ Yes 2 □ No	28d. Describe n	ow injury occurre	ed .	
lor Attending after death. Director: After in by the fune	cat	2 Accident investigatio 3 Suicide 6 Could not b		home farm str			28f Location (S	treet and Numbe	r or Rura	l Route Number
tal or A rs after al Direct of in by	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	city)	eet, lactory, on		City or Tow		. 0171010	a riogio reginaci,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one) Certifying Pl Certifying Pl Certifying Pl Certifying Pl Certifying Pl	nysician: To the best of my ki miner: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred at the vestigation, in r	e time, date and place ny opinion, death occu	e, and due to the corred at the time, o	cause(s) and mar date and place, a	ner as st nd due to	tated. the cause(s)
To t Withi To tl	Ž	29b. Signature and title of certifier	0			cense number		29d. Date signed		
		· yea	MW)		10	58303	4	APRIC	1	~006
10		30. Name and a dress of person who	completed cause of death (Ite		Print)	rles St 1	NO BACI	nmone	no	21204
Stat Registra		31. Date filed (Month, Day, Year) -	32. Registrar's Sig	nature	9 -					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** APRIL CHARLES LEWIS MORTON **1**9 2006 7:35 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Morningside House of Laurel Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**Д**М 2□F Months Days Hours Yrs. 579-07-1588 Director 91 March 5, 1915 Illinois Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1√Yes 2 No Director Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a 7700 Cherry Lane #118 20707 U.S.A. death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? *FEPYes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.
other then "naturel", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White δ WWII 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Grade 12 Contractor Building Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil. Department of Health and Mental Hy Important: If tiem 27 is marked oth any unity or other traumatic eventone. Charles S. Morton ဂ္ Frances Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Morton, II / son 20905 15217 Peachstone Drive Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State West Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/21/06 Odenton, MD 21. Signature of Funeral Son 22. Name and Address of Facility
Donaldson Funeral Home, P.A. <u>/</u>_M00770 313 Talbott Avenue Laurel, Maryland 23a. Part 1. Enter the disease, or of shock, or heart failure. List of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebral Thrombosis minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure 3378 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed the buriat-transit Coronary Artery Disease years and resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached Records, P.O. 9 Unknown 9 Unknown Š signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ XProbably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 **X** 2 X X0 1 Yes 1 Yes Division of Vital il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6XX ther (Specify) 1 ☐ Yes 2 🗶 💢 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Living To the Hospital or Attending Phwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28b. Time of 27. Manner of Death 28c. 28d. Describe how injury occurred injury at Work? Certification 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 12 Gertifying Physician: To the best of my knowledge death conutried at the time, date and clicitie the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Time) William A. Warren, 321 Prince George Street MDLaurel, Maryland 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State 6 2006 Registrar

		•	For State Registrar	State of Ma	aryland /	-	rtment o <i>ificate</i>				giene Reg. No	HIIIh	en-quilgh-en	3112
			Decedent's Name (First, Middle, Last)							2. Date of De	eath Day	y Ye	ar	3, Time of Death
	Physici /Medic		Donald Henry Mais	el						April	24,	2006		2:05 A M
	Examin	0.01	4a. Facility Name (If not institution, give st	reet and number)			4b. City, To	wn, or Loca	ation of Death		4c.	. County of D	eath	
		69	Joseph Ritchie Hos		. // (+ h	Cab da 1	If Under 1	Baltir	nore Inder 24 Hrs.	8. Date of Bir			N.	
	Funeral		5. Social Security Number 6. Sex	M 2□F	e (In yrs. last bi	Yrs.			ours Min.	(Month, Da	av. Year)		Counti	nce (State or Foreign y) vland
	Director		215-14-0081 Usual Residence of Decedent		0.5					вер. с	د ۱۰۰۰ و د	722	riar	y Lanu
	yland		10a. State 10b. County		10c. City, Tov	vn or Loca	ation						10	d. Inside City Limits
	a-1 sl	ctor	MD Baltim	ore			Balt	imore	9					1 ☐ Yes X☐ No
	ith the	Oire	10e. Street and Number				10f. Zip Co	ode			10g. Cit	izen of Wha	t Count	ry?
	ath w	rail	1139 Linden Avenue					2122						States
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show final Examiner must be notified at	Funeral Director	11. Marital Status 1 1 ☐ Never Married 2 ☒ Married	 Was Decedent I Armed Forces? 1 X Yes 2 □ N 		13. W	as Deceden Yes, specify	t of Hispan Cuban, Me	ic Origin? (Spe exican, Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - A Black, V		
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1942-	11	☐Yes 2【X	No Sp	ecify:			Specify:	Wh	ite
Ş	thou stura	ed	15. Decedent's Educ	ation	168	a. Decede	ent's Usual (Occupation			16b. K	ind of Busine	ess/indu	ustry
215	S . 2	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	+)	(Give k. life. Di	ind of work of NOT use	done du <i>ri</i> ng retired)	g most of workir	19	τ	Inited	Sta	ates
21215-0036	giene giene	Completed	12			Le	tter (Carrie	er		F	ostal	Sei	cvice
pu	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.	Be	17. Father's Name (First, Middle, Last)					18.	Mother's Name	(First, Middle	, Maiden	Sumame)		
yla	shoutd ind Men marke umatic	ဥ	Walter Henry Maise							Sophia				
Maryland	12 sh and I e m		19a. Informant's Name/Relationship (Typ	_					Jumber or Rura				te, Zip (Code)
	is 1 and 2 should of Health and Mer Item 27 le marke r other traumatic		Marie E. Maisel W 20a_Method of Disposition	ife	20b. Place				, Balti	lmore,		21227 ocation - City	or Tow	vn. State
AM Baltimore,	Pages nent of I int: If It		1 N Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemete	ery, crema	atory or othe	er place)	ļ			,		
音音	it. Partmer		4 □ Donation 5 □ Other (Specify) 21. Signature of coneral Service License		Loudo		rk Cem Name and					timor		
SA B	permit. Pages Department of I Important: If its eny injury or o	1	Merrio	WOR	11013	V			Spring	rose F				
N			23a. Part1. Enter the disease, or complic	ations that caused	the death. Do	1		-				ub, III		Approximate Interval Between
0	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each iir	2 .	Sic.	4							Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence		Thys	or or c	ancer				-	years
20	Examiner	8	Commission for our distance											
73	B =	ner	Sequentially list nonditions if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):								
7	cate be executed physicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dura to /ou o	a consequence	-6							-	
£09	clen d	E E		Due to (or as	a consequence	, ui).								
4 68760		dicai	d.											
×	death certific e attending p ed for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome								23d. Date of	deliver	у
	death e atte	by Physician/M	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic preg Other (s <i>pec</i>					Month		Day Year
00	that the de ed by the detached	hys	9 Unknown	9□ Unknown				_						
S, F,	es tha gned be de	oy P	Part II. Other significant conditions conf	tributing to death b	ut not resulting	in the und	derlying cau	se given in	Part I.	1				cause of death?
Spi	v require been sk									1 🗆	Yes 2	□No 3□] Proba	bly 4 Unknown
()	S & S	Completed								24a. Was	psy	prior	to com	sy findings available pletion of cause of
	The I	Son								perfe 1 ☐ Yes	ormed?	deat	h? Yes 2	2□ No
/ita	ysician: T is certificat director, pa	Be (25. Was case referred to medical examiner?					1	Place of Death	(Check only	one)			11
₹ 50 m	Physion this call dire	2	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ospital:		utpatient Time of			☐ Nursing Hon	ne 5 Resi		6 Other (S	Specify)	Hospice
7	ling After fune	lon	1 ☑Natural 5 ☐ Pending	28a. Date of Inju- (Month, Dat	y Year)	Injury	M	. Injury at Work? 1 ☐ Yes		ou. Describe	now inju	ry occurred		
β isi	deat deat ctor: / the	licat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	urv - At home, t	arm, stre				8f. Location ((Street an	nd Number o	r Rural	Route Number,
⊆ ĕ		Certification:	4 Homicide	building, etc	c. (Specify)	,	, , , , ,			City or To	wn, State	e)		
0	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledg	je, death	occurred at	the time, d	ate and place, a	and due to the	cause(s)) and manne	r as sta	ted.
()	To the Hosi within 24 ho To the Func completely f	edical	(Check only 2 Medical Examin	and manner sta	ted.	na/or inve				at the time,				
•	To t To t	Σ	29b. Signature and title of certifier				29c. L	icense nur				te signed (M		
	141		1 1/80 MD					724	110		A	DYIL	4,2	006
_/	NO		30. Name and address of person who con	ey Hospia	ce 83	(Type, P		aw S	+ B	alfimo	re, N	JD.	212	01
4.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 6 2006	ag. Registra	ar's Signature	Joseph								

State of Maryland / Department of Health and Mental Hygiene, State Registra Amend #10c&f&22 Per FH g855 State Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death . Day 2006 April 21, Da **Physician** 4:30 A M Jose Dizon Mercado /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Camp Springs, 5001 Leah Court 8. Date of Birth (Month, Day, Year) June 4, 1919 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Months Days Hours Philippines 216 88 3903 86 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other then "natural", or items 23s or 28s-f show traumatic event, tra Madical Examinar must be notified at Camp Springs 1 Yes 2 No Clinton Maryland Prince George's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5001 Leah Court 20735 **20746** United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give XX Year or Dates: 1 Never Married X2X Married 1 Yes 2 TNO Baltimore, Maryland 21215-0036 Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Banking Teller 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francisco S. Mercado and Mental Placida Dizon ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 20618 Bridgeport Court, Potomac, Va 20165 Lucila Ochoada (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) April 29, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; if ite
eny injury or oti 200F tXXBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur easi'S 22. Na**Al Reservit of B**acility Lee Funeral Home, Inc. 663301d Alexandira Ferry Road, Clinton, MD 20735 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PARKINSON. 3 YE) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) cete has been signed by the cage 2 should be detached in 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes or Attending Physicien: Atter this certitic tuneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Medicai Certification; To 1 TYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendir within 24 hours after death.
To the Funeral Director: All completely tilled in by the tu death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifie 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 35-50H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Stuart Goodman, M.D. 7501 Surratts Road #309, Clinton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State porte Registrar 2006

			For State Registrar	State of M	aryland /		ent of Hea ate of De		lental Hygi	ene 006	3 14
	Dhuaisi		1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic			Alvin Geor	ge McNi	sh			April	18, 2006	4:52pm M
	Examin	er	4a. Facility Name (If not institution,			4b. Ci	ity, Town, or Loc			4c. County of Deat	
		- A		orfield Roa	d ge (In yrs. last i	himheless) If I In		<u>ckville</u> Under 24 Hrs.		Mont	gomery
	Funeral Director			1 X M 2□F	80	Yrs. Month		lours Min.	8. Date of Birth (Month, Day, June 28,	Year) Go	hplace (State or Foreign
*	* * v		577-20-2876 Usuel Residence of Decedent		00				Julie 20,	1925 Wasi	nington, D. C.
	how	. [10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits
	Ba-1 s	cto	Maryland Mon	tgomery			Roc	kville			1 ☐ Yes 2 No
	or 24	Director	10e. Street and Number			10f.	Zip Code		10	g. Citizen of What Co	untry?
	s 23s			norfield Ro		10.14		0853			States
	item item	Funeral	11. Marital Status 1 □ Never Married 21 Married	12. Was Decedent Armed Forces d 1 X Yes 2 □	?	If Yes, s	pecify Cuban, M	nic Origin? (Sp lexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
21215-0036	urs af	5	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2XI No S₁	pecify:		Specify:	White
ğ	be filed within 72 hours after death with the Maryland Ital Hygiene. sd other than "natural", or items 23a or 28e-f show event, the Medical Experiest must be neitlisd at	Completed	15. Decedent's (Specify only highest		16	Sa. Decedent's U	sual Occupation work done durin	n na most of work	ing 1	6b. Kind of Business/	4-7-4
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	Tuse retired)	ig most or work	ing		
2	filed will Hygien Sther the	Co		5+		Res	earch Cl			Federal G	overnment
n d	be fill d oth	Be	17. Father's Name (First, Middle, La	ist)			18.	Mother's Name	e (First, Middle, M	faiden Sumame)	
2	should be ind Mental marked o	ပ	Alvir 19a. Informant's Name/Relationship	Greene Mc		Ob Mailing Addr	acc (Street and	Numbor or Rus		Neal Hari City or Town, State, 2	
Maryland	d 2 tra		Linda C.P. McN		,					le, Maryla	
	1 and Health Iem 27 other tr		20a. Method of Disposition	ATSII/ WITE	20b. Place	of Disposition (/	Name of		Date 2	Oc. Location - City or	
Baltimore,	Pages nent of H ent: if ite ury or of		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			creek C			ril 2006	Washingt	on D C
量	artme orter injur	ı	21. Signature of Funeral Service Li		NOCK	22. Name	and Address of				neral Home/ onsin Avenue
m	Depa impo any i			DELA	M00335				e, Inc. 20814-35		onsin Avenue
100	Physician /Medical Examiner		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. RESPI	d the death. Dine. RMTORY s a consequence	o not enter the in	node of dying, su				Approximate Interval Between Onset and Death 2 MONTS
8760,	The taw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence	ce of):	0(-2				210
P.O. Box 6	es that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal dea at time of death		c pregnancy (specify)			23d. Date of del Month	ivery Day Year
	signed by	<u>م</u>	Part II. Other significant condition	s contributing to death	but not resulting	g in the underlyin	g cause given in	Part I.		acco use contribute to s 2 □ No 3 💢 Pr	the cause of death?
Sor	w requir been si should	ete	0						24a. Was ar	24b. Were au	Itopsy findings available
al Records,	i: The lay icate has r, page 2	Completed							autopsy perform 1 Yes 2	prior to death? MNo 1 □ Yes	completion of cause of
	Physicien: r this certifica ral director, I) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital:	O [[[]	Outpatient 3	Other		h (Check only one		
ot	Physical distribution	: To	27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		o. Time of	28c. Injury at Work?	4 Nursing Ho	28d. Describe ho	nce 6 Other (Spec winjury occurred	city)
0	rding th. : Afte	the state of	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga		ay Year)	Injury M		2 🗆 No			
Division of Vital	of or Atter after dea i Director d in by the	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 289. Flace of it	njury - At home, tc. (Specify)	, farm, street, fac	tory, office		28f. Location (Str City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospitel or Attending Physicien: The tav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (Physician: To the bes kaminer: On the basis and manner s	of examination						
	To the To the comp	ğ	29b. Signature and title of certifier				29c. License nu		29	d. Date signed (Monta	h, Day, Year)
	/X		> Sem (1	uj.			D3627	2		April 19	, 2006
	20,1		30. Name and address of person w								
	0		Steven T. Kari	ya, M.D. 1	1501 Ge	orgia A	venue, 1	515 Wh	eaton, Ma	aryland 20	902-1956
100	Sta Registi		31. Date filed (Month, Day, Year) APR 2	6 2006 2005	trar's Signature	y spea	W				

Position Comment Provided Position Provided Position	_			1 - For State Registrar	State of Maryla		artmer <i>rtificat</i>					iene eg. No.	006	3	15
Decoration of the property of		Physic	ian	Decedent's Name (First, Middle, Last)			,						Year	3. Time o	of Death
TOTAL MODILITY 1					Ne	1				A 1	20	3006		7 bw	
216-12-903 216-12		Exami	ner			1 01	0	4 .		of Death	•	4c. C		1	
Director 2.16—1.2-29.03 2.16				Johns Hopkins B			-			24 Hrs	0. D	<u></u>			
Dural Reviewed Description Total Country				3.5	14 005	• •					(Month, Day,	Year)			
State											June 9	, 19.	ZI Per	nsylva	ania
State		ylan how		10a. State 10b. County	10c. C	City, Town or Lo	cation							10d. inside (City Limits
State		e Ma	cto	Maryland Bal	ltimore				Dun	dalk				1 ☐ Yes	; 2]X No
State		ii b or 28	Oic o				10f. Zip		004		1	0g. Citize	n of What Co	untry?	
State		ath w													
State		er de Item	une		Armed Forces?	U.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)	14			
State	36	irs aff	by		If Yes, Give		1 🗆 Yes	2 € No	Specify:			S	pecify: V	Thite	
State	ŏ	2 hou	ted	15. Decedent's Educ	cation	16a, Dece	dent's Usua	al Occupa	ation			16b. Kind	ot Business/l	ndustrv	
Privision Middical Examiner Processor of the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arest. Privision Middical Privision Privisio	215	hin 7	ple			(Give	kind of wo DO NOT u	rk done a se retired,	luring most)	t of workir	ng			,	
Privision Middical Examiner Processor of the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arest. Privision Middical Privision Privisio	2	ad wit	Son			Mec	hanic	:				Iı	ndustri	ia1	
Privision Middical Examiner Processor of the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arest. Privision Middical Privision Privisio	pu	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	Ukn.			Ì	18. Mothe	r's Name	(First, Middle, M	Maiden Su	ımame)		
Privision Middical Examiner Processor of the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arest. Privision Middical Privision Privisio	yla	Meni Merike	မ												
Privision Middical Examiner Processor of the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arest. Privision Middical Privision Privisio	Nar	12 sh h and f is m										-			
Privision Middical Examiner Processor of the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arest. Privision Middical Privision Privisio	e,	1 and 100ltl						1000	11 1100	-	147				
Privision Middical Examiner Processor of the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arest. Privision Middical Privision Privisio	Jor	ages to to to to to to		1 Burial 2 Cremation 3 Re	emoval from State	cemetery, crei	natory or o	ther place	· .						
Privision Middical Examiner Processor of the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arest. Privision Middical Privision Privisio	Ħ	it. Pertant	"	-											
Physician Michigan Physic	Ba	Depo Impo Impo Impo		21. Signal of Furieral Service Election		/ / /								ıc.	
Privisican Middleal Examiner To grade a consequence of the conditions of the condit				23a. Part1. Enter the disease, or complic	cations that caused the dea	ath. Do not ent	922 W er the mod	ise e ot dyind	Ave.	<u>Dun</u>	dalk, M	aryla est.	and 21		ite
Part	ı	Physician		Immediate Cause (Final	e cause on each line.	٠								Onset and	Death
Sequentially list conditions, farry, leading to mediate cause. Green theology my resulting in death plant indicated events in resulting in the underlying cause given in Part I. If FEMALE: 23d. Date of delivery 23d. Date of deli	Į.						fory	tailu	.16					13 No	surs
A contribute of the contribute of the cause of death of the contribute of the cause of death of the cause of d		Examiner		Commentative line and discount	Large ole	ural es	facio	2No						400	v 5
Section Sect	-	D =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse		0								1
Section Sect		ecute and trans	am	that initiated events C.			Meu	MOU	19					1 we	2H
FEMALE: 23c. If yes, outcome of pregnancy 1 1 1 1 1 2 2 2 1 2 2	60,	be ex cien a	E E	Tooding in doubly said	Due to (or as a conse	quence ot):									
The state of the s	387	physicate sthe	dica	d.											
The state of the s	×	certif ding use as	/Me		3c. If yes, outcome of pregr	nancy						224	d Date at dain		
The state of the s	ğ	death etter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fel	tel death 3						230		,	Year
The state of the s	o.	oy the	hysi		9□ Unknown										
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death Check only ond		s thai		Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause ot	death?
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death Check only ond	ğ	quire en sig	edt								1 ☐ Ye	s 2 🗆 1	No 3□Pro	bably 4 🗆	Unknown
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death Check only ond	00	aw re is ber 2 sho	piet									1 2	24b. Were aut	opsy tindings	available
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death Check only ond	č	The I	E					-			perform	egh?	death?		ause ot
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)	ita	ian: ortifice ctor, I	0						26. Place	of Death		1	10.00	20110	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)	<u>~</u>	hysic his ce I dire			ospital: 1 / Inpatient 2	☐ ER/Outpatien	t 3□ DC	Othe	r: 4 🗆 Nur	rsing Hom	ne 5 Reside	nce 6	Other (Speci	fy)	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)	0	ng P			28a. Date of Injury (Month, Day Year)		2	8c. Injury Work	at ?	2	8d. Describe ho	w injury o	ccurred		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)	sio	tendi leath. tor: A the fu	cati	2 ☐ Accident investigation					'es 2□N						
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)	Ξ	or At fiter of Direct in by	iii	dataminad	28e. Place of Injury - At I building, etc. (Spec	home, farm, str lify)	eet, tactory	, office		2	8f. Location (Str City or Town	eet and \ State)	lumber or Rur	al Route Nun	ıber,
Odruen & Janvier, MD, PhD Res-000 April 2006 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Adrien Janvier, Johns Hopkins Bayuras, 4940 Eastern Ave, Baitimore, MD 21224 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	_	pital ours a eral (29a Certifier A Continue Ph.	icien: To the best at any to	poulodos de d		ah th = ''	n d-+-	d alc ::					
Odruen & Janvier, MD, PhD Res-000 April 2006 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Adrien Janvier, Johns Hopkins Bayuras, 4940 Eastern Ave, Baitimore, MD 21224 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		24 ht Fun etely	dica	(Check only 2 Medical Examin	er: On the basis of examin	ation and/or in	estigation,	at the time in my op	e, date and inion, deat	h occurre	nd due to the ca d at the time, da	use(s) an te and pla	d manner as s ace, and due t	stated. o the cause(s	s)
Odruen & Janvier, MD, PhD Res-000 April 2006 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Adrien Janvier, Johns Hopkins Bayuras, 4940 Eastern Ave, Baitimore, MD 21224 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	412	omple	Me	29b. Signature and title of certifier			290	. License	number		29	d. Date s	igned (Month,	Day, Year)	
30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Advien Januier, John's Hopkins Bayung, 4940 Eastern Ave, Baitimore, MD 2024 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				Danien & a	am non mo	PIOD	R	es -	000)	t	Ingl	00m 2	006	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		1 000	21												
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	10	11 1		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Tohns Hopki	as Bax	(Ules	. 49	40 E	aste	M Ave	Ba	Himore	MO 5	HZZU
TOTAL STATE OF THE	V 1	Sta Registr		31. Date filed (Month, Day, Year)	32./Registrar's Sign	atore						,			

			For State Registrar		S	State of	f Maryla		artmen rtificat			and M	lental Hy	giene Reg. No.	06	3	16
	Physici /Medic		1. Decedent's Nam SINH	e (First, Midd		'AN		NO	GUYEN				2. Date of De Month APRIL	Day	2006		ne of Death
	Examir		4a. Facility Name (GENESIS	f not institutio	n, give stre 'AGE C	et and nun ENTER	nber) R Y		4b. City,		Location o	of Death			County of De		
	Funeral Director		5. Social Security N 216-39-9	076	6. Sex	2 🗆 F	-	. last birthday) 85 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 10-12-	th y, Year) 1920		inhplace (Sta Country) ietnan	ate or Foreign
	the Maryland 28a-f show	ō	Usual Residence of 10a. State MD	10b. County	ALTIM	ORF.	10c. C	city, Town or Lo	cation		ROSE	DAT.F					le City Limits Yes 2 √No
	ath with the Maryla 23a or 28a-f shows	Director	10e. Street and Nu 1209 BE	mber					10f. Zip	Code	212			10g. Citiz	en of What C	Country?	<u> </u>
036	after des or Itams	by Funeral	11. Marital Status 1 Never Mart 3 Widowed	ied 2∑X Mar	12.	Was Dece Armed For 1 Tes If Yes, Give Year or Da	dent Ever in I rces? 2 XNo e ates:		Was Deced f Yes, spec				ecity Yes or No Rican, etc.)		4. Race - Am Black, Wh	nerican India	
Maryland 21215-0036	ed within 72 hours ygiene. ter than "natural", t, the Modical Ex.	Completed	Elementary/Second 12		est grade c	ion ompleted) College (1	-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us OWI	k done d e retired) IER	uring mos			RI	od of Busines:	·	
yland	2 should be filed withir and Mental Hygiene. is markad other than aumatic avant, Ire M	To Be		NOWN				UNKNOW			UI	NKNO			(UNKNO		
	5 5 5 E		MUI THI	NGUYE			204	5	BERK	AVE		R	OSEDALE	, MD	212	237	
3altimore,	9° = 5		20a. Method of Dis 1 □ Eurial 2 4 □ Donation	☐ Cremation 5 ☐ Other (5	Specify)	oval from S	State	cemetery, crer OLY ROS	ARY C	ther place EMET	ERY 4	4-26-		DU	ation - City o	, MD	
Bal	permit. Pac Department Important: any injury once.		21. Signature of Fu	6				1	211 0	HESA	CO A	/ENUI		EDALE	FUNERA E, MD	AL HOM 2123	
0, A	Physician /Medical Examiner	Exa	23a. Part1. Enter I shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list co- if any, leading to in- cause. Enter Unde Cause (Disease or that initiated event- resulting in death)	onditions, nomediate sinjury s	a b c	Due to (or as a conse	Quence of): QVAS	NI CV	A LA HY	R /	•	CIDE	ÈN"			Matter Services And Dearth
P.O. Box 68760,	The law requires that the death certificate be tte has been signed by the attending physici bage 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2	months? ⊒No	d 23c.	1 Live bi	come of pregrifth 2 Fet ant at time of own	al death 3	Ectopic pro					23	3d. Date of de Month	elivery Day	Year
	w requires that been signed b should be deta	by	Part II. Other signi	ficant conditi	ons contrib	outing to de	ath but not re	sulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to		e contribute t	to the cause	
Vital Records,		Completed								-					24b. Were a prior to death?	completion	ngs available of cause of
Division of Vita	Attending Physician: Th r death. actor: After this certificate by the funeral director, pag	Certification; To Be	25. Was case referexaminer? 1 Yes 2 2 27. Many r of Deal 1 Natural 2 Accident 3 Suicide	No	Hos ng igation	28a. Date o (Month	of Injury h, Day Year)	ER/Outpatien 28b. Time of Injury	M 2	A Other Bc. Injury Work' 1 Y	4	rsing Hor	(Check only one 5 Reside Resid	lence 6	occurred		
Divi	oital or Attendurs after deathurs after deathurs sral Diractor:		4 Homicide	determ	nined			nome, farm, str ify)					28f. Location (S City or Ton	m, State)			lumber,
	To tha Hospital or a within 24 hours after To tha Funeral Dirac completely filled in b	Medical	29a. Certifier (Check only one) 29b. Signature and	2 Medical	Exeminer	en: To the : On the ba and mann	sis of examin	owledge, death ation and/or inv	estigation,	in my op	inion, deat	d place, a	and due to the dead at the time, d	date and p	olace, and du	e to the caus	
	¥ 1 8)	Hary	6 hm	gk	M I	>]	> (41	60	A	PRI	L24	,20	06.
	\		30 Name in a del	th. Day Year	who comp	(100	egistrar's Sign	BAUT	Imo	PE,	M	AR	FLAT	14/1	2(2	25	470
đe:	Sta Registr			PR 2 6		Bear	1000 00	alure Age	See !								

		•	State of Maryland / Department of Health ar 1 - State Registrar Certificate of Death	nd Mental F	lygiene Reg. No.	005	13117
	May 18	- 3	Decedent's Name (First, Middle, Last)	2. Date of			3. Time of Death
***	Physici		GWENDOWLYN PANTLOW- Green	Month	Day	Year O G	4:10 PM
	/Medic	_	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of			County of Deat	
ار.	Examin	er	3609 GELSTON DRIVE BALTIMORE			NA	
-	Cunaval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4 Hrs. 8. Date of	Birth		nplace (State or Foreign untry)
32	Funeral; Director		216.42.1711 1 M 25 F 60 Yrs. Months Days Hours	Min. (Month,	Day Year) 7. 104 F	Co	MD
(27)			Usual Residence of Decedent	100-0			
	ylan		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ma Ma	Director	MD N/A BALTIMORE				1 Yes 2 □ No
	or 28	lire	10e. Street and Number 10f. Zip Code		10g. Citiz	en of What Co	untry?
	15 will will will will will will will wil	a	3609 GELSTON DRIVE 21229			USA	
	dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin Armed Forces? 15. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, If	in? (Specify Yes or Puerto Rican, etc.)	No- 1	4. Race - Ame Black, White	
9	or It	F	1 □ Never Married 2 2 Married 1 □ Yes 2 M No Specify:			Engelifie	
ğ	urel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			BL	ACK
Ž	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or Iteme 23s or 28s-f show avent. I're Madical Examena nual be indiffied at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of life, DO NOT use retired)	of working	16b. Kin	d of Business/	ndustry
2	within ne.	шb	Elementary/Secondary (0-12) College (1-4or 5+)		p	ETAIL	
7	Hygie Hygie othar t		TO IN CHILD	's Name (First, Mid			
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan ad Mental Hygiene marked othar than "naturel", or Iteme 23e or 28e-1 show marked othar than "naturel", or Iteme 23e or 28e-1 show marked othar than "naturel".	Be			OLLERS	•	
Ž	should ind Men marke umetic	ဥ	KOBERT GASSAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number				in Code)
Ma	h and 7 Isr		A STATE OF THE PARTY OF THE PAR				ip Code)
	1 and Health Bm 27 ther tr		WALTER GREENE JR 3000 GEISTON DRIV 20a. Method of Disposition (Name of	IE BALIC	20c. Loc	ation - City or	Town. State
و	Pages nent of int: If It		1 KBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	05 0		-	
Baltimore,	it. Pi						NN, MD
Ba	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumetto: 0000.		VAUGHN C. GREENE	FUNERA	L SERV	ICE	
			23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as ca			21229	Approximate
10.3			shock, or heart failure. List only one cause on each line.		y arrest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Lung Can Ce	1			5 months
	Examiner		Due to (or as a consequent of):				
77		_	Sequentially list conditions, b. Due to (or as a sunsequence of):				
/	ed sit	ulu u	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	xecu and	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed obysician and the burial-transit	<u>ea</u>					
687	icate phys	edical	0.				
×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		2:	3d. Date of deli	verv
Box	atter for u	Physician/M	in the past 12 months?		111-	Month	Day Year
o.	that the de led by the a detached t	ıysı	1 Yes 2 Mo 9 Unknown 9 Unknown				
٥.	res that igned b be deta	J P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. D	id tobacco us	e contribute to	the cause of death?
of Vital Records,	uires 1 sigr 1d be	d by	Hypertension	1	Yes 2□	No 3∏Pr	obably 4 Unknown
00	w require been si should I	Completed	Degeneration wint disease	24a. W	tas an	24b. Were au	topsy findings available
Re	helay e has ge 2	m d	Defendant your res	— at	utopsy erformed?	prior to death?	completion of cause of
a	n: Ti ficate or, pa	e Co	25. Was case referred to medical 26 Place of	1 Ye		1 Li Yes	2□ No
⋚	Physician: r this certificantal director.	00	examiner? Hospital: Other	of Death (Check on		DO# /O-	
o	Physic ruthis ral di	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	sing Home 5 R	be how injury		ciry)
on	ding h. Afte	tlor	17 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No.	0			
S	Attending ir death. ector: After by the fune	flca	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office			Number or Ru	ral Route Number,
Division	after I Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or	Town, State)		
	spite nours neral		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	place, and due to	the cause(s)	and manner as	stated.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death and manner stated.	n occurred at the tin	ne, date and	place, and due	to the cause(s)
	To the within To the Comp	Ž	29b. Signature and title of certifier 29c. License number		29d. Date	signed (Monti	n, Day, Year)
	-		· Vankara D216	49	1/1	mil 2	14 2006
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 11		1 - 0	2 (2
	.		S. BASKARAN 3455 Wilkens Mi	Baltime	u. /	10 2	21
4	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
-65	Regist	rar.	APR 2, 6, 2006				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9130 A M 2006 Anri. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SECOUNS Butto metro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 9, 1969 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100 M 2 F Months Days Hours 220-64-3816 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3237 Bero Rd 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 Widowed 4 Divorced Year or Dates: nature!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Entrepreneur permit. Pegas 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any liquy or other traumatic event 906. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald Alexander Parisien Emily Marie Phillips ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Campbell / sister 4038 South Babcock St. Melbourne, FL 32901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/24/2006 Odenton, Maryland West Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd Lansdowne, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) sete hes been signed by the pege 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2∏ No 1 Yes 2/1NO 1 ☐ Yes al or Attanding Physician: T s after death. Il Director: After this certificet ed in by the funeral director, pe Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide To the Hospital o within 24 hours aft To the Funeral DI 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0052950 April 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 W

State Registrar

Battimore

APR 2 6 2006

31. Date filed (Month, Day, Year)

			For State Registrar	State of Mary	land / Dep		Health and M	lental Hygi	•	13119
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month APR		
k	/Medic Examin		Marjorie Pritche 4a. Facility Name (If not institution, give CT AG NES				or Location of Death		4c. County of De	
	Funeral Director		5. Social Security Number 6. S		yrs. last birthday)					irthplace (State or Foreign Country)
	nyland show		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo	ocation			1,2, 110,	10d. Inside City Limits
	th the Ma or 28a-1 e roulie	Director	MD 10e. Street and Number		Baltimo	re 10f. Zip Code		10	g. Citizen of What (1 Yes 2 □ No Country?
	ma 23a	neral [115 E. Melrose A	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		nerican Indian,
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f ehow or other traumatic event, it a Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 ADivorced	Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:		1 ☐ Yes 2K No		rican, etc.)	Black, Wh	lack
Maryland 21215-0036	ithin 72 h ne. nen "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work		16b. Kind of Busines	s/industry
1d 2	e filed wil al Hygien I other th	Be Co	6 17. Father's Name (First, Middle, Last	none	Disa	abled	18. Mother's Nam		none Maiden Sumame)	
rylai	should be ind Mental marked c	To	Willie Daugherty 19a. Informant's Name/Relationship		19h Maili	ing Address (Street	Betty Da		City or Town, State	Zin Code)
	and 2 s ealth an n 27 ls i		Artie Shaw/legal		10				, MD 2120	
Baltimore,	Parity Parity		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ☒ Other (Special	Removal from State	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other pla		Date	20c. Location - City o	or Town, State
Balt	permit. Departr Imports any inju		X mass	Wade Direct	S S	altimore.	omy Board		Baltimore	Street
*	Physician		23a. Pag1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	P	NEUMO	NIA	or respiratory arre	st,	Approximate Interval Between Onset and Death UNKNOWN
m)	/Medical Examiner		Sequentially list conditions	Due to (or as a co	nsequence of):	SEPSIS				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):					
3760,	ate be executed hysician and he burial-transit	cal	resulting in death) Last	Due to (or as a co	nsequence of):					
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date of d Month	elivery Day Year
	w requires that is been signed by should be deta	b	Part II. Other significant conditions	contributing to death but no	t resulting in the t	underlying cause gr	ven in Part I.			to the cause of death? Probably 4 (Pt/nknown
Division of Vital Records,	The law re ate has bee page 2 sho	Completed						24a. Was ar autops perform 1 \sum Yes 2	prior to ned? death:	autopsy findings available completion of cause of es 2110
Vita	sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatie	nt 3C DOA Ott	bor	th (Check only one	nce 6 □Other (Sp	annife)
ion of	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Inju Wo		28d. Describe ho		rectify)
Divis	al or Atte s efter de i Directo d in by th	Certification:	3 Suicide 6 Could not to determined		At home, farm, st pecify)	reet, factory, office		28f. Location (Str City or Town		Rural Route Number,
	ne Hospital	Medical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of moments of examiner: On the basis of examiner stated.	y knowledge, dea mination and/or in	th occurred at the tinvestigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
)	To the b within 24 To the R complete	Σ	29b. Signature and title of certifier 30. Name and address of person who	AAMIR (CHEEM).	29c. Licen:	se number 0 6 3 0 2 5		APR 16	nth, Day, Year)
	1		30. Name and address of person who	completed cause of death	(Item 23a) (Type IKESV14	Print) AAM/	MD .	2/208	D. 4312	-04.P)
	Sta Regist		31. Date filed (Month, Day, Year)	2. Registrar's s	Signature	de .				

MARJORIE

PRITCHETT,

			For Stete	State of M		d / Depa	artmen	t of H	lealth a	and Me	ntal Hyg	iene	1116	13120
			Registrer	()		Cei	rtificate	9 01 1	Jeam		. Date of Dea	eg. No.		2 Time of Dooth
п	Physicia	an	1. Decedent's Name (First, Middle,	1						2	Month	Day	Year	
	/Medic	al	4a. Facility Name (If not institution,	ince	·)		4h City	Town or	Location of	of Death	April		County of Dea	
	Examin			1 00 13	A A	iem	D. 019,	alh	MOY	_		10.1	NA	
	Funeral		W	. Sex 7. A		ast birthday)	If Under		If Under	24 Hrs. 8	. Date of Birth	14 . 1		rthplace (State or Foreign Country)
	Funeral Director		229-62-3059	1√2 M 2□ F	58	Yrs.	Months	Days	Hours	Min.	(Month, Day lay 14,	, Year) 194	7 V	irginia
	p .		Usual Residence of Decedent		1									
	show	_	10a. State 10b. County			, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Be-f.	Director	VA Spotsy	lvania	Spo	tsy1v								
	death with the Maryland ms 23e or 28e-f show rinust be rigitled at	吉	10e. Street and Number 6410 Toney Lane				10f. Zip				,	-	en of What C	Country?
	s 23e	Funeral		12 Was Decedent	t Ever in III	3 13 1		2553		inin? (Speci	fy Ves or No.	USA		nerican Indian,
	item item	ij.	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces 1 2 Yes 2	? ! No	3.	If Yes, spec	ify Cuba	in, Mexicar	n, Puerto Ri	fy Yes or No- can, etc.)		Black, Wh	
36	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□ Yes	2⊠ No	Specify:				Specify:	White
Maryland 21215-0036	filed within 72 hours after Hygiene. other than "natural", or ite ent. The Medical Examina		15. Decedent's			16a. Dece	dent's Usua	I Occupa	ation	t of working		16b. Kin	d of Business	s/Industry
215	thin 7 9. an "n Med	ed l	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired	during mos ()	t or working				
2	filed wi Hygien ther th	Completed	12			Contr	act 1	Cechi					vil_Se	rvice
nd	be filed within 72 hours after death with the Marylar ital Hyglene. id other than "natural; or items 23e or 28e-f show event. Its Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, La	,							First, Middle,	Maiden S	Sumame)	
<u>₹</u>	2 should be and Mental Is marked o	၉	Cedon Blanton I							ille V	-			~
<u>a</u>	12 sh and rism		19a. Informant's Name/Relationshi				-				Route Number			
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Wife - Donna Tor. 20a. Method of Disposition	ley Prince	20b. PI	6410 ace of Dispo	sition (Nan	ne of		Spore	ylvani			2553 r Town, State
פֿר	Pages nent of l int: If it		1 ☐ Burial 2 🖾 Cremation 3		∍ Cổ	metery, crec venant	natory or o	ther plac Eral	:e)	0//22				Davis Hwy.
Baltimore,	it. Partme		4 □ Donation 5 □ Other (Special Signature, of Funeral Service Li			rvice	Crema 2. Name an			04/22 tv	/06 <u>]</u>	red	ericks	burg, VA.
B	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other 2005.		1/200 8	A. I.	CC033	36	Cexer 4801	lant Jef	Fune Day	ral Se	ervice V. Fre	der	icksbu	rg, VA 22408
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause	d the death	. Do not ent								Approximate Interval Between
Ų,	Pnysician :		Immediate Cause (Final	nly one cause on each				4						Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (tr a.	s a consequ	Kespin	MULT	10	uvu	C				
	Examiner		One continue the ties and distance	Comn	nunity	1 Aco	Luire	d	Pneu	re moni	a			12 days
4	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as			V	201						
,	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a		uppr	essio	N						
60,	ate be executed sysician and he burial-transit	cal E	100011119 111 0001117 2220	No	- Ha	hring	ixin	noh	enna					
687	physics the I			d	1100	MMID	1911	4 10 10	11141					
	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	by Physiclan/Med	IF FEMALE:	23c. If yes, outcom	e of pregna	ncy						2	3d. Date of de	elivery
P.O. Box	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pr Other (sp					-	Month	Day Year
o	at the de by the a tached	hysi	9 Unknown	9□ Unknown										
	w requires that been signed b should be deta	y P	Part II. Other significant condition	s contributing to death	but not resu	ilting in the u	nderlying c	ause give	en in Part I	l.	23e. Did to	bacco us	se contribute i	to the cause of death?
ğ	aquire an sig										1 🗆 Y	es 2 🗓	₹No 3 🗆 F	Probably 4 Unknown
Records,	e law re has bei ge 2 sho	Completed									24a. Was a			autopsy findings available completion of cause of
č	The ate ha	mo:									perfor		death?	
Vital	ysicien: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?							of Death (Check only or	18)		
	Physic this o	ို	1 ☐ Yes 2 ▼No	Hospital: 1 Inpat		ER/Outpatier			4 🗀 NU	Marine Control of Control	5 Reside			ecity)
U C	Attending Ph er death. ector: After th by the funeral	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	lay Year)	28b. Time o Injury	f 2	8c. Injun Worl	yat k? Yes 2 🗆		d. Describe h	ow injury	occurred	
Sic	death death tor: / the	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 290 Place of Ir	niury - At ho	me farm str			163 2		f. Location /S	treet and	Number or F	Rural Route Number,
Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Certification:	4 ☐ Homicide determin	building, e	etc. (Specify	")	001, 140101)	, 55			City or Tow			
_	To the Hospital or within 24 hours after To the Funerel Dit completely filled in		29a. Certifier 1 Certifying	Physician: To the bes	t of my know	wledge, deat	h occurred	at the tin	ne, date ar	nd place, an	d due to the c	ause(s)	and manner a	as stated.
	n 24 h	Medical	(Check only 2 Medical E	keminer: On the basis and manner s	of examinat	ion and/or in	vestigation	, in my o	pinion, dea	ath occurred	at the time, d	ate and	place, and du	ie to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	00		0	290	. Licens	e number		2	9d. Date	signed (Mor	nth, Day, Year)
}			growne	J. Bul	lard	/ M	1)	F	185	568		Api	ril 20	, 2006
	8		30. Name and address of person w	ho completed cause of							- 3	1		,
	7		31 Date filed (Month Day Vace)	South Greek	ru St	reet.	Balti	more	, mut	212	U L			
•	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6	2006	trar's Signal	x de	CARO N							
		1	.5 0		Sal A	1	1							

1- For State of Maryland / Departme Certification	ent of Health and Mental Hygiene 16 13 2 1 ate of Death Reg. No.
1. Decedent's Name (First, Middle, Last) Physician	Date of Death Month Day Year 3. Time of Death Year
/Medical Cecilia M. Price	April 24, 2006 5:00 a ^M
	ty, Town, or Location of Death 4c. County of Death
E Copiel Copyrity Number C Copy 7 App (forum test high do.)	TOWSON Baltimore der 1 Year If Under 24 Hrs. 8, Date of Birth 9, Birthplace (State or Foreign)
Director 212-09-5127 Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Md Baltimore Baltimo	ore 1□Yes 2⊠No
Md Baltimore Baltimore Baltimore Baltimore Baltimore 106. Z 814 Stoneleigh Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{New Power Married} \) 2 \(\text{Married} \) 1 \(\text{New Power Married} \) 1 \(New Power Marr	Zip Code 10g. Citizen of What Country?
814 Stoneleigh Rd.	21212 USA
11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces 7 13. Was Decedent Five in U.S. Amed Forces 7 1 Description 2 Decedent Ever in U.S. Amed Forces 7	cedent of Hispanic Origin? (Specify Yes or No- pecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
O	2.☑No Specify: Specify:
To a. State 10b. County 10c. City, Town or Location 10c. City Town or Locat	white sual Occupation 16b. Kind of Business/Industry
(Specify only highest grade completed) (Give kind of wife. DO NOT Give kind of wife. DO NOT Give kind of wife. DO NOT College (1-4or 5+)	work done during most of working use retired)
15. Decedent's Education (Specify only highest grade completed) (Give kind of with the body of the complete o	emaker Home
Md Baltimore Baltimore Md Baltimore Baltimore Md Baltimore Most Baltimore Md Baltimore Most Baltimore 106. City, Town or Location Md Baltimore 107. Zity Fown or Location Md Baltimore 108. Street and Number 814 Stoneleigh Rd. 11. Marital Status 11. Never Married 2 Married 11. Was Decedent Ever in U.S. Amed Forces? 11. Was Decedent Ever in U.S. Amed Forces? 11. Was Decedent Ever in U.S. Amed Forces? 11. Yes, Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Peter Moniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	Caroline Zagata
The policy of the part of the	ess (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	neleigh Rd. Baltimore, Md. 21212
20a. Method of Disposition 1	r other place)
21. Signature of Funeral Service Licensee	owskifacijuneral Home P.A.
Engene 1201	Dundalk Ave. Baltimore, Md. 21222
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.	
A STATE OF THE PARTY OF THE PAR	Oncot and Dooth
/Medical resulting in death) Due to (or as a consequence of):	thronic Smorths the pulmonary disease It To
Sequentially list conditions, b. (h von 'c obstmc	twe pulmonary disease 1 Tu
that initiated events c. Due to (or as a consequence of):	
Solution of the past 12 months? 1	
Affica 68	
X O S O S O S O S O S O S O S O S O S O	pregnancy 23d. Date of delivery
O The part of the	
O. See that the population of	cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Signal and the law requires the law requirements and the law requirements are required to medical examiner?	1 Yes 2 No 3 Probably 4 Unknown
The law requir sate has been single 2 should Completed	24a. Was an 24b. Were autopsy findings available
The lave are the law page 2.	autopsy prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to medical examiner? 1	
Hospital: 1 Inpatient 2 ER/Outpatient 3 D	26. Place of Death (Check only one)
0 5 9 7 1	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury. At home farm, street factors	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 1 Report 1 Pending investigation investigation 1 Pending investigation 1	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No
	OOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dullding, etc. (specify) The property of the	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) and at the time, date and place, and due to the cause(s) and manner as stated. Son, in my opinion, death occurred at the time, date and place, and due to the cause(s)
building, etc. (Specify) 1	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) and at the time, date and place, and due to the cause(s) and manner as stated. and, in my opinion, death occurred at the time, date and place, and due to the cause(s) 9c. License number 29d. Date signed (Month, Day, Year)
Duilding, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred to the property one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. Characteristics of examination and/or investigation and manner stated.	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dullding, etc. (Specify) 1 To proper suppose the control of the c	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) and at the time, date and place, and due to the cause(s) and manner as stated. and, in my opinion, death occurred at the time, date and place, and due to the cause(s) 9c. License number 29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 22° 2008 2100 **Physician** Kenneth J. Robbins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** March 8,1922 Maryland Months Days Hours 1**X**M 2□F 212-18-5935 Director 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2€ No Md Worcester Ocean City Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4709 Coastal Highway 21842 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State of MD Elementary/Secondary (0-12) College (1-4or 5+) Assessor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Robbins Ada Wallace 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4709 Coastal Highway Ocean City MD Anna Robbins /wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 4/27/06 Bayview Crematory 1 ☐ Burial ②☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 21. Signature of Funeral Service Licens mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Deliton. hs **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimal accause. Enter Underlying Cause (Disease or injury Tua to for as a consumence of Examine anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No certificate 1 □ Yes 2 1 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division (1 Matural 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fo the within 24 hours To the Funeral Directory hours after 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dukes 9733 31. Date filed (Month, Day, Year) 32. Regiştrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

2/61

Raddins, Kenneth

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 20 2006 **Physician** Stella M. Roark /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River 25 Helicopter Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2**K** F 77 Aug. 22, 1928 Tenn Yrs. 225-32-4257 Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "neturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Middle River MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA 25 Helicopter Drive death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status e filed within 72 hours after d il Hygiene. other than "neturel", or item Yes 2 XNo f Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygient Important: if Item 27 ie marked other tha eny injury or other traumatic event. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Emmit Poe 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Helicopter Drive Baltimore MD 21220 Fred Roark / husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Holly Hill Cemetery 4/24/06 Baltimore MD 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave.Balto.MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 21221 Approximate Interval Retw 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEWRAIT Physician /Medical Due to (or as a consequence of): Examiner POTITY ROIDISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The taw requires that the deeth certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medicai 23b. Was decedent pregnant 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home S Residence 6 Other (Specify) 1 Yes PNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0-48025 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEAC ME, BATO, WD 21237 RN1, MO 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland		artment tificate			d Mental H	ygiene Rag. No		13124
	Physicia	an į	1. Decedent's Name (First, Middle, Last)						2. Date of Month 04	Death 2 I	^y 286	3. Time of Death 0.7:00 A
)	/Medic Examin	uı -	Mary A. Rusk 4a. Facility Name (If not institution, give 4407 Hopper Ave.	street and number)			own, or Loc	cation of De	eath		. County of Dea	th
H	Funeral		5. Social Security Number 6. Se	х 7. А	-	ast birthday)	If Under 1	Year If	Under 24 H	Irs. 8. Date of Month, June			thplace (State or Foreign outling)
	Director		213-26-8873 1 Usual Residence of Decedent		75	Yrs.				June	24,	1930 B	
	anyland show	5	10a. State 10b. County MD Baltim	ore	10c. City	Ralti	nore M	farvla	and				10d. Inside City Limits 1 ☐ Yes 2√ No
	in the N or 28a-i	Funeral Director	10e. Street and Number				10f. Zip 0	Code			10g. Ci	tizen of What Co	ountry?
	sath wit	eral D		Ve.	Ever in U.S	S 13 '	212		anic Origin?	(Specify Yes or	No-	USA 14. Race - Ami	erican Indian,
920	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, the Medical Examinar must be rediffied at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 21 If Yes, Give Year or Dates:	? No		lf Yes, specif	fy Cuban, N	Mexican, Pu Specify:	ierto Rican, etc.)		Black, Whi	te, etc.
5	72 hou	eted	15. Decedent's Edi (Specify only highest grad	ication le completed)		(Give	dent's Usual kind of work DO NOT use	done duri	in ing most of i	working	16b. K	(ind of Business	/Industry
7 7	d within rithan rithan	Completed	Elementary/Secondary (0·12)	College (1-4or	5+)		nsuran		lerk		In	surance	Company
ana	id be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Eugene Meehan							Name <i>(First, Mide</i> La Keel	dle, Maider	n Sumame)	
Mary	d 2 shou Ith and M 27 Is mark traumat		19a. Informant's Name/Relationship (T Louis E. Rusk So	ype, <i>Print)</i> N		19b. Mailii 17	ng Address (Picker	Street and	Number or 1 Squa	Rural Route Nui are Owin	nber, City ga Mi	or Town, State, 11s, MD	Zip Code) 21117
nore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparation of Health and Mental Hygiene. Importment of Health and Mental Hygiene. any injury or other traumatic event, the Medical Examinat must be rediffed at once.		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 → 4 □ Donation 5 □ Other (\$pecify)		T C4	lace of Dispo	psition (Name Properties	e of 1 ECE T	y 04,	/23/06	Balt	ocation - City or imore,	Town, State MD 21229
Бант	permit. F Departm Importar any inju		21. Signature of Funeral Service Licen							ral Home Baltimo	re MD	21229	
) !	Physician		23a. Part. Enter the disease, or conference, or heart failure. List only commediate Cause (Final disease or condition resulting in death)	. Meta	asta	Tic	ter the mode	of dying, s		diac or respirator			Approximate Interval Between Onset and Death 8 Months
	/Medical Examiner			Due to (or a	s a consequ	uence of):							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	uence of):							
8/60,	certificate be executed adding physician and use as the burial-transit	dical Exar	that initiated events resulting in death) Last	Due to (or a	s a consequ	uence of):							
ã	rtificate ng phys a as the	Medic	IF FEMALE:	0.									
O. Box	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 🗌 Fetal	Ideath 3	Ectopic pre Other (spe				-	23d. Date of de Month	Day Year
٦.	The law requires that the de ste has been signed by the a page 2 shoutd be detached	by	Part II. Dthar significant conditions co	ontributing to death	but not rest	ulting in the u	inderlying ca	use given i	in Part I.			,	o the cause of death?
Vital Records,	law requias been 2 shouk	Completed								24a. W	as an atopsy arformed?	24b. Were a prior to death?	utopsy findings available completion of cause of
<u>8</u>	n: The ficate h or, page		25. Was case referred to medical					20	6 Place of	1 ☐ Ye	s 2 0 N		
	hysicie his cert Il direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatie		A Other:	4 🗆 Nursin	ng Home 5 🗆 R	esidence	6 Other (Sp	ocity) RESIDENCE
ouo	Attending Physicien: if death. •ctor: After this certific. by the funeral director, I	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, E	Jay Year)	28b. Time o Injury	of 28	Bc. Injury at Work? 1 Yes	t s 2 □No	28d. Descri	oe now inji	ury occurred	
Division of	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	289. Place of 1	njury - At ho etc. (Specif	ome, farm, st	reet, factory,	, office			n (Street a Town, Sta		Rural Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	yslcian: To the bestiner: On the basis and manner	of examina	owledge, dea ation and/or in	th occurred anvestigation,	at the time, in my opin	date and p ion, death o	lace, and due to	he cause(: ne, date ar	s) and manner and place, and du	s stated. e to the cause(s)
	To the within To the compli	Me	29b. Signature and little of certifier				29c	. License n	number	2	29d. D	ate signed (Mor	oth, Day, Year)
,	T,		30. Name and address of person who	completed cause of	f death (Item	n 23a) (Tvna	Print)	04	6118	2	14/	21/7	000
	10		JANGT COO	PER MI) 1	447	YOR	Kf	201	Luth	ervi	116 V	1D 21093
	Sta Regist	ate rar	31. Date filed (Month, Day, Near)		strar's Signa	4	and I		1				

	Registrar	- (Fig. 4 A 41 + 11	1 = 11				rtificate	0 0/ 1		2	Date of De	Reg. No	o.		3. Time of Death
n	1. Decedent's Nam Nancy R												^y 2006	Year	2:45 P M
al er₊	4a. Fecility Name (eet and num	ber)		4b. City,	Town, or	Location of I		1		. County o		
	6610 Sen	eca Dri	.ve					umbia					oward		
- 2	5. Social Security N	Number	6. Sex	4 2 XF	. Age (In yrs.		If Under Months		If Under 24 Hours	Hrs. 8. Min.	Date of Bir (Month, Da	th y, Year	1000	9. Birthpl Coun	lace (State or Foreign try)
	577-44-6 Usuel Residence o					72 Yrs.					June I	δ,	1933	wasn	ington, D
	10a. State	10b. County			10c. Cit	ty, Town or Lo	ocation							1	Od. Inside City Limits
ctor	Maryland	Howard	1		Co1	umbia									1 ☐ Yes 2 No
Oire	10e. Street and Nu						10f. Zip					10g. C	itizen of W	hat Coun	itry?
Funeral Director	6610 Sene	eca Driv		Was Dagge	dent Ever in U	18 13	210		ispanie Origin	2 (Specif	fv Yas or No			- Americ	an Indian.
Fune	11. Marital Status 1 ☐ Never Mari	ried 2∏ Marni		Armed For	сө s ? 2 [2 No	ļ			ispanic Origir in, Mexican, I	Puèrto Ric	can, etc.)			k, White,	
þ	3 XWidowed			tf Yes, Give Year or Da	9		1 🗆 Yes	2LALNo	Specify:				Specify:	Whit	e
Completed	(Spe	15. Decedent' cify only highes	's Educa	tion completed)		16a. Dece (Give	dent's Usua kind of wo	al Occupa	ation during most o	f working		16b.	Kind of Bu	siness/Ind	dustry
mp	Elementary/Sec			College (1-	4or 5+)			ise retired	")			0	II.a.		
	17. Father's Name		Last)		*	Homem	aker		18. Mother's	Name (i	First, Middle		n Hon n Sumame		
To Be	William V	Villough	hby I	Roche					Ellen	Bra	nsfor	d Yo	ungei	r	
_	19a. Informant's N	lame/Relationsh	hip <i>(Type</i>	e, Print)					and Number					State, Zip	Code)
	Suzanne I	R. Frost	t/da	ughter					Lane J		-			O'h T-	
	20a. Method of Dis	sposition ! XCremation	3 □Rer	moval from S	state i	Place of Disponentery, cre			l l		1 26,		Location -		
	4 ☐ Donation 21. Signature of F	5 ☐ Other (Sp	pecify)	4	Ch	esapea			ory ss of Facility Crema	200					Maryland
	23a. Part1. Enter shock, or he	the disease, or art failure. List	complica only one	ations that can cause on ea	MO 1. aused the dea ach line.	251 B	ever1	de ol dyır	ng, such as ca	ardiac or	respiratory a	arrest,	ar no		Approximate Interval Between Onset and Death
ledical Examiner	disease or condition resulting in death Sequentially list of any, leading to cause. Enter Unicause (Disease of that initiated even resulting in death)	conditions, immediate for injury	a. b. c. d.	Due to (aused the dea ach line. The deal of the d	quence of):	ever1	de ol dyır	g, such as ca	ardiac or	respiratory a	arrest,			MT 2102 Approximate interval Between Onset and Death
edical	disease or condition resulting in death Sequentially list of any, leading to cause (Disease of that initiated even	conditions, immediate party is the state of	a. b. c. d.	Due to (Due to (Due to (Live b	or as a consector as	quence of): quence of): quence of): annoy and death 3:	Ectopic p	pregnancy	ione	ardiac or	respiratory a	arrest,		e ol delivo	
edical	disease or condition resulting in death Sequentially list of any, leading to cause. Enter United as the cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 □ Yes 2	conditions, immediate control in injury its Last	a. b. c. d.	Due to (or as a consector as	quence of): quence of): quence of): annoy ant death 3 death 5	□Ectopic p	pregnanc;	,	ardiac or	23e. Did	tobacco	23d. Dat Mor	e ol deliventh	ery Day Year he cause ol death?
by Physician/Medical	disease or condition resulting in death Sequentially list of any, leading to cause. Enter United as the cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	conditions, immediate control in injury its Last	a. b. c. d.	Due to (or as a consector as	quence of): quence of): quence of): annoy ant death 3 death 5	□Ectopic p	pregnanc;	,	ardiac or	23e. Did	tobacco	23d. Dat Mor	e ol deliventh	ery Day Year
by Physician/Medical	disease or condition resulting in death Sequentially list of any, leading to cause. Enter United as the cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	conditions, immediate control in injury its Last	a. b. c. d.	Due to (or as a consector as	quence of): quence of): quence of): annoy ant death 3 death 5	□Ectopic p	pregnanc;	,	ardiac or	23e. Did 1	tobacco	23d. Dat Mor D use contri 2 \(\subseteq \text{No} \)	e ol deliventh	ery Day Year he cause ol death?
by Physician/Medical	disease or condition resulting in death Sequentially list of any, leading to cause. Enter United as the cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	conditions, immediate control in injury its Last	a. b. c. d.	Due to (or as a consector as	quence of): quence of): quence of): annoy ant death 3 death 5	□Ectopic p	pregnanc;	,	ardiac or	23e. Did 1	tobacco	23d. Dat Mod b use contr 2 \subseteq No	e ol deliventh	ery Day Year he cause ol death? bably 4 □Unknow bopsy findings availab impletion of cause of
Be Completed by Physician/Medical	idisease or condition resulting in death Sequentially list of any, leading to cause. Enter Uniteraction Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 1 yes 2 9 1 Unknow Part II. Other sign	onditions, immediate party is continued in the program to the prog	a. b. c. d. 23	Due to (Due to (Due to (Due to (Live b 4 Pregn 9 Unknown	or as a consector as	quence of): quence of): quence of): anancy tal death 3 death 5 sultting in the	□Ectopic p □ Other (s underlying	pregnancy pecify)	yen in Part I.	of Death	23e. Did 1 24a. Wa auto peri 1 Yes (Check only)	tobacco	23d. Date More	e ol deliventh ribute to t 3 □ Prot Were autorior to codeath? □ Yes	ery Day Year he cause of death? pably 4 Unknow posy findings availab mpletion of cause of
To Be Completed by Physician/Medical	idisease or condition resulting in death Sequentially list of any, leading to cause. Enter United as the cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 1 yes 2 9 1 Unknow Part II. Other sign	onditions, immediate party is continued in the program to the prog	a. b. c. d. 23	Due to (Due to (Due to (Due to (Live b 4 Pregn 9 Unkno	or as a consector as	quence of): quence of): quence of): annoy ant death 3 death 5	□Ectopic p □ Other (s) underlying	cause giv	yen in Part I. 26. Place oner: 4 \(\text{Nursery at} \)	of Death	23e. Did 1 24a. Wa auto peri 1 Yes (Check only)	tobacco	23d. Date More	e ol deliventh ribute to t 3 □ Prot Were autorior to codeath? □ Yes	ery Day Year he cause of death? pably 4 Unknow posy findings availab mpletion of cause of
To Be Completed by Physician/Medical	If FEMALE: 23b. Was deceded in the past 1 1 Yes 2 25. Was case releasements of the past 1 25. Was case releasements of the past 1 26. Was deceded in the past 1 27. Wanner ol De 1 27. Manner ol De 1 28. Natural	onditions, immediate benty injury its continuity its continuity its continuity its continuity its continuity injury	a. b. c. d. 23	Due to (Due to (Due to (Due to (Live b 4 Pregn 9 Unkno	or as a consector as	quence of): quence of): quence of): quence of): anncy lat death 3 death 5: sulting in the	□Ectopic p □ Other (s, underlying	cause give 28c. Injury	yen in Part I. 26. Place oner: 4 \(\text{Nursery at} \)	of Death sing Hom	23e. Did 1 24a. Wa auto peri 1 Yes (Check only) e	tobacco	23d. Date More	e ol deliventh ribute to t 3 □ Prot Were autorior to codeath? □ Yes	ery Day Year he cause of death? pably 4 Unknow posy findings availab mpletion of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1 1	erred to medica No ath Portion The proposition of the proposition o	a. b. c. d. 23 ons cont	Due to (Due to	or as a consector as	quence of): quence of): quence of): quence of): anncy lat death 3 death 5: sulting in the BER/Outpatite 28b. Time Injury	□Ectopic p □ Other (s underlying ent 3□ D ol M	cause give 28c. Injury Wo	y 26. Place oner: 4 □ Nur: ry at rk?	of Death ssing Hom	23e. Did 1 24a. Wa auto per 1 Yes (Check only e	tobacco	23d. Date Model Mo	ribute to to a superior to code att?	ery Day Year he cause of death? pably 4 Unknow posy findings availab mpletion of cause of
Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign 25. Was case relexaminer? 1 Yes 2 27. Manner of De 1 2 Natural 2 Accident 3 Suicide	erred to medica No ath Simple	a. b. c. d. 23 ons cont	Due to (Due to	or as a consector as	quence of): quence of): quence of): quence of): quence of): ancy at death 3 death 5 sultting in the BER/Outpatit 28b. Time Injury home, larm, s	□Ectopic p □ Other (s, underlying ent 3□ D ol M M ath occurred	cause give 28c. Injury office at the tr	yen in Part I. 26. Place oner: 4 Nur: ry at rk? Yes 2 N	of Death sing Home	23e. Did 1	tobacco Yes s an opsy formed? 2X N sidence s how in (Street own, Sta	23d. Dat More ouse control of the co	e ol deliventh inibute to t	ery Day Year he cause of death? pably 4 Unknow posy findings availab mpletion of cause of 2 No fy) al Route Number,
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decode in the past 1 1 Yes 2 9 Unknow Part II. Other sign 25. Was case relexaminer? 1 Yes 2 27. Manner ol De 1 27. Manner ol De 1 28. Natural 2 Accident 3 Suicide 4 Homicide (Check only one)	ent pregnant 2 months? END No ath 5 Pendir investing of Could determine the condition of the could determine the could be could determine the could determine the could be could determine the could determin	a. b. c. d. 23 ons cont Ho ng gigation not be mined ng Physit Examin	Due to (Due to	or as a consector as	quence of): quence of): quence of): quence of): quence of): ancy at death 3 death 5 sultting in the BER/Outpatit 28b. Time Injury home, larm, s	□Ectopic p □ Other (s underlying ent 3□ D of M street, facto	cause give 28c. Injury office do at the tron, in my office	yen in Part I. 26. Place oner: 4 Nur: ry at rk? Yes 2 N	of Death sing Home	23e. Did 1	tobacco	23d. Dat Mor Duse control 2 No 24b. No 1 1 6 Oth tury occurr and Numb ate)	e of deliverable of the control of t	ery Day Year he cause of death? pably 4 \(\subseteq \text{Unknow} \) posy findings availab impletion of cause of 2 \(\subseteq \text{No} \) fy) al Route Number,
edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign 25. Was case relexaminer? 1 Yes 2 27. Manner ol De 1 27. Manner ol De 1 28. Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	ent pregnant 2 months? END No ath 5 Pendir investing of Could determine the condition of the could determine the could be could determine the could determine the could be could determine the could determin	a. b. c. d. 23 ons cont Ho ng gigation not be mined ng Physit Examin	Due to (Due to	or as a consector as	quence of): quence of): quence of): quence of): quence of): ancy at death 3 death 5 sultting in the BER/Outpatit 28b. Time Injury home, larm, s	Ectopic p Other (s) Other (s) underlying ent 3 D ol M street, facto	cause give 28c. Injury office do at the tron, in my office	26. Place oner: 4 \(\triangle \tria	of Death sing Home	23e. Did 1	tobacco	23d. Dat Mor Duse control 2 No 24b. No 1 1 6 Oth tury occurr and Numb ate)	e ol delivernith ribute to to a superior to codeath? er (Special red er or Rur anner as sand due to de (Month,	ery Day Year he cause ol death? pably 4 □Unknow posy findings availab mpletion of cause of 2□ No fy) al Route Number, stated. to the cause(s) Day, Year)
edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign 25. Was case releaxaminer? 1 Yes 2 27. Manner ol De 1 2 2 3 3 3 3 3 3 3 3	erred to medical determined title of certifier and title of certifie	a. b. c. d. 23 ons cont Hong igation not be nined I Examin er	Due to (Due	or as a consector as	quence of): quenc	Ectopic p Other (s underlying ent 3 D ol M street, facto ath occurre- investigatio 25	cause give the transition of t	26. Place oner: 4 Nurry at rk? Yes 2 Nurry at rk.	of Death sing Hom 26 20 21 J place, an	23e. Did 1 24a. Wa autoper in the per	tobacco	23d. Dat Mod by use control 2 \(\text{No} \) No \(\text{1} \) 1 \(\text{No} \) 6 \(\text{Oth} \) tury occurr and Numb ate) (s) and maind place, Date signed 11 25	e ol delivernith ribute to to a superior to codeath? er (Special red er or Rur anner as sand due to de (Month,	ery Day Year he cause ol death? pably 4 □Unknow posy findings availab mpletion of cause of 2□ No fy) al Route Number, stated. to the cause(s) Day, Year)

Please Type or Print in Black Indelible Ink Sabrina Rosenberg State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Medical Examiner 2323 hrs Sabrina M. Rosenberg April 22, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) oreign Months Hours Days Director 9 1 M 2 X F Country) Virginia 218-47-3040 1996 Usual Residence of Decedent 10b. County any 10c. City. Town or Location 10d Inside City Limits or 28a-f show Yes 2 X No Maryland Montgomery Bethesda hours after death with the Maryland Director items 23a or 28a-l ust be notified at c 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5015 Wyandot Court 20816 United States Funeral 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes ÷ Yes 2 X No specify: Widowed Divorced Give Yea Specify "natural", White ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I and 2 should be filed within 72 l Health and Mental Hygiene item 27 is marked other than " the Medical MD 21215-0036 Student Elementary School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be traumatic event, Edward Louis Rosenberg <u>Brenda Ines Pilares</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Rosenberg/Mother 5015 Wyandot Court, Bethesda, Maryland 20816 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, Department of H Important: Hit 1 X Burial 2 Cremation 3 Potomac United Methodist Removal from State April 28, Donation 5 Other Specify Cemetery Potomac, Maryland Name and Address of FacilityRobert A. Facthersda-Chevy Chase, Inc. Pumphrey Funeral Home, 7557 Wisconsin Ave. 21. Signature of Funeral Service Licensee Bethesda-Chevy Cha Bethesda, Maryland M00803 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED item#23a,27,perME,G856,6/29/06 TT To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery use as the 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Fetal death Day Year past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown Unknowr contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 ✓ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ 2 FR/Outpatient 3 DOA Inpatient this Nursing Home 5 Residence 6 1 🗸 Yes 28a Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural hours after death Pending Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 23, 2006 30. Name and address of perso who completed cause of death (Item 23a) Deputy Chief Medical Examiner Jack Titus MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State

Registrar

Physician /Medical **Examiner** The law requires that the death certificate be executed P.O. Box 68760, Records. Division of Vital the Hospital or Attanding Physician: death.

Completed by Physician/Medical Examiner as the l use signed by the a certificate Be Jo this After 1 Certification: Director:

Physician

/Medical

Examiner

Funeral

Director

or 28a-f ahow

or Items 23a

"natural".

f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic avant, tos Medical

permit. Pages 1 Department of H Important: If Ite any injury or ot

death

Pages 1 and 2 should be filed within 72 hours after and thealth and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Completed by Funeral

Be

within 24 hours after To the Funeral Direct

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 2 6 2006

29b. Signature and title of certifier





2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1 - For State Registrer	State of M	laryland / Depa	artment of H			jiene 0 0 6	13128
			Decedent's Name (First, Middle, Last,)				2. Date of Dea	th	3. Time of Death
	Physici /Medic		Jerome Wilson St	ewart				April 1	Day Ye.	10:30 AM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De	eath	4c. County of D	
			3142 Gracefield			Silver Sp			Montgon	
	Funeral Director		123-09-1020	x 7. A]M 2□F	ge (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days		fin. 8. Date of Birth (Month, Day July 24	, Year)	Birthplace (State or Foreign Country) EW York
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f aho	ō	MD Montgome	ry	Silver	Spring				1 ☐ Yes 2√ No
	1 the	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What	Country?
	h with	a D	3142 Gracefield R	oad MG606	5		20904		USA	
	de d	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of Hi	spanic Origin?	(Specify Yes or No- uerto Rican, etc.)		merican Indian, /hite, etc.
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mentel Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic avent, its Medical Examinar must be rediffed at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 If Yes, Give]No	1□Yes 2\\\ No	Specify:	,	Specify:	
8	hour		15. Decedent's Edu	Year or Dates:		dent's Usual Occupa	ation		16b. Kind of Busine	ss/Industry unk
Maryland 21215-0036	n na	Completed	(Specify only highest grad		(Give	kind of work done of DO NOT use retired	furing most of	working	TOD. THING OF EGOING	dir.
212	d with	E	12	5+		Lesperson				
b	be filed intel Hygie of other is avent, It	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		
<u>yla</u>	2 should be and Mentel is marked is raumatic av	2	Jerome Lincoln S				Clara I	Maude Wils	on	
Mar	2 sh and is m	li	19a. Informant's Name/Relationship (T)					Rural Route Numbe	30 56	
e,	1 and Health Brm 27 thar t		Frances Stewart/s	ouse	3142 20b. Place of Dispo	Gracefie:	ld Road	MG606 Si	Lver Spri 20c. Location - City	or Town State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or othar tra ance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F		cometery cre-	matory or other plac	9)			3. 13.11, 3.213
	artme ortan injury	1	21. Signature of Juneral Strates Licens	/		2. Name and Addres	s of Facility			
B	Ped ping		Romald S.	lade 1	ector St	tate Anato Altimore,		rd 655 W. 201	Baltimore	Street
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that cause	ed the death. Do not en			diac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		gestive hear	rt failur	e			Onset and Death Years
	/Medical		resulting in death)		s a consequence of):	I TULLUI	-			
	Examiner		Sequentially list conditions if any, leading to immediate		onary arter	y disease				years
	ed sit	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):					
	xecut and	Examiner		c. Due to (or a	s a consequence of):					
8760,	cate be executed bhysician and the burial-transit	dicalE		d						
89	uficate g phys as the	ed	_	u					1	
Box	eath certific ettending pl I for use as t	N.	23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregnancy			23d. Date of	
о П	The law requires thet the death certificate be executed sie hes been signed by the ettending physician and page 2 should be deteched for use as the burial-transit	Physician/Med	in the past 12 months? 1 Yes 2 No			Other (specify)	 		Month	Day Year
o.	thet the di ed by the deteched	Phy	9 ☐ Unknown Part II. Other significant conditions co		but not enquising in the	andrebina sausa seusa	n in Oast I	220 Did to	ha aga uga gantahut	e to the cause of death?
ds,	signed be del	5	aortic regurgi			moenying cause give				Probably 4 Unknown
Š	w requir been si should	etec	autere regurgi	Lacion	· •			24a. Was a	-	
Re	he lav	Completed						 autops perfor 	med? prior deat	autopsy findings available to completion of cause of 1?
ā	in: Ti		25. Was case referred to medical				26 Place of	1 ☐ Yes Death (Check only or		/es 2□ No
5	ysicia s cert direct	To Be	examiner?	Hospital: 1 ☐ Inpat	tient 2 ER/Outpatie	nt 3 DOA Othe		g Home 5 esid		Specify)
0	Attanding Physician: r death. sctor: After this certific by the funeral director, i		27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D					ow injury occurred	, ,
jois	andin sath. or: Af	atic	2 ☐ Accident investigation	,			Yes 2 □ No			
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	treet and Number o n, State)	Rural Route Number,
	urs al		One Contiller All Description Share	 			E 1.00 - 0.10			
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exemi	iner: On the basis and manner s	t of my knowledge, deat of examination and/or in stated.	n occurred at the tin ivestigation, in my of	ne, date and pi pinion, death o	ace, and due to the di ccurred at the time, o	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	ro th comple	Me	29b. Signature and title of certifier	/		29c. License	number	2	29d. Date signed (M	onth, Day, Year)
			1 flor/no	MM	7	D 345	90	A	pril 20,	2006
			30. Name and address of person who c				a .	100 0000		
			Roy Fried MD				Spring	, MD 20904		
9	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	aske I				
	Regist	el .	APR 2 6 20	Ub Range	ASI ST PO	Should make				

			1- State Registrar Amend Item State of Mary Case, 0	1926/06thb Health and Certificate of Death	d Mental Hygien Reg. N	2006 13129
	Physicia	an	1. Decedent's Name (First, Middle, Last) Donald Hammond Sparklin, Sr.		2. Date of Death Month April 20,	3. Time of Death Unknown M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 2032 Featherbed Lane	4b. City, Town, or Location of Di		c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 77 Age (In yrs. last birth 1881)	day) If Under 1 Year If Under 24 h	Hrs. 8. Date of Birth (Month, Day Year January 09,	9. Birthplace (State or Foreign 1929 Maryland
	ס		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Be-f eh	Director	Maryland Baltimore Woodla			1 ☐ Yes 2 🛣 No
	with th		10e. Street and Number 2032 Featherbed Lane	10f. Zip Code 21207		ed States of America
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28e-f ehow other treumatic event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Korea	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	72 hour "natural"	Completed b	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of ife. DO NOT use retired)	working 16b.	Kind of Business/Industry
2121	yene.	omp	Elementary/Secondary (0-12) College (1-4or 5+)	vice Technican	Те	lephone Company
pue	be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last) Barton Abbot Sparklin		Name (First, Middle, Maide Margaret Smi	
Maryland	should nd Mer marke umatic	은		Mailing Address (Street and Number of		
-	permit. Pages 1 and 2 Department of Health a Importent: if Item 27 le any injury or other tree		1 X Burial 2 Cremation 3 Removal from State	Disposition (Name of crematory or other place) Lew Memorial PK (Date 20c. 20c. Syl	Location - City or Town, State Kesville, Maryland
Balt	permit. Depart Import any inj pnce.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 8728 Liberty Rd.	Randallstown	Funeral Directors, I ,MD 21133-4784
	Physician /Medical Examiner		23a. Part1. Enter the disease, a complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the condition of the condition or condition o	canoma of all	diac or respiratory arrest.	Approximate Interval Between Onset and Death of County Coun
8760,	icate be executed physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	· V	w - 0 7 <i>0</i>	
.O. Box 6	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	uires that signed by	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐Unknown
of Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	completed			24a. Was an autopsy performed: 1 Yes 2	
Vita	Physician: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner? Hospital:	Othor	Death (Check only ne)	
	ing After	ion; To	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 1 Matural 5 Pending	Datient 3 DOA 4 Nuisi	ng Home 5 Mesidence 28d. Describe how in	
Division	deatl deatl ctor: y the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)			and Number or Rural Route Number, ate)
البسط	To the Hospital or At within 24 hours after C To the Funeral Direct completely filled in by	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.			
	To the within. To the comple	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (liter 23a) (DUL/	14 ap	ress mo
			ELLICOLD FREDERMARD.	SULANDIA RALY	EMORE, M	D 21229
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 6 2006 APR 2 6 2006	e e		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dav Year **Physician** April 22, 2006 2P C. Dora Steinmetz /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Chevy Chase Montgomery Brighton Gardens at Friendship Heights Date of Birth (Month, Day, Year)
Oct 18, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1□ M 2□F Days Hours Months Canada 1913 92 Director 109-14-8950 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show than "natural", or Items 23a or 28a-f shov the Madical Examiner must be notified at 1 □ Yes 2 □ No Director Chevy Chase Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20815 USA 5555 Friendship Blvd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item any Injury or other traumetic event, the Medical Examine 1 ☐ Yes 2☐No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 25 No Specify: Specify: þ 3 TWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ida Randolf Thomas B. Costain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1624 29th St NW, Washington, DC 20007 Son Thomas Steinmetz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-26-06 Baltimore, MD Bayview Crematory Funeral Service V Cense 22. Name and Address of Facility Fink Funeral Home, P.A. uecosus 21061 Gregory MO1148 426 Crain Hwy S, Glen Burnie, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Artherosclerotic Heart Disease vears Ecominer Due to (or as a consequence of): Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ettending physician and for use as the burial-tran Due to (or as a consequence of). Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of deeth? signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown RefluxDisease þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? been si Completed Osteoporosis s certificate has t director, page 2 s 1 ☐ Yes 2 ☐ No 1 Tes director. Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) ASST LIVE INC. 1 Yes 21 No 2 ER/Outpatient 3 DOA this : After this funeral of 27. Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 🗌 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: efter death.

Certification: To nerai Director: A filled in by the fo within 24 hours of To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edicai (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number

Garaensat Friendship Hights

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Musher Brighton

31. Date filed (Month, Day, Year) APR 2 6 2006

State

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item#8, perFH state of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death Day 2006 **SERBU** APRIL 21, ELEANOR **JEAN** 9:00 A 4b. City, Town, or Location of Deeth 4c. County of Death 4a. Fecility Name (If not institution, give street and number) FORT WASHINGTON PRINCE GEORGE"S FORT WASHINGTON HOSPITAL 8. Date of Birth (Month, Day, Year) 1923 9. Birthplace (State or Foreign Country) OHIO If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Months 1 M 4 F Days Hours 82 Yrs. 302 14 4986 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. State 10b. County GEORGE"S ACCOKEEK PRINCE 1 □ Yes 2012/100 MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20607 105 CALVERTON CIRCLE UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes ŽIXNo If Yes, Give 1 ☐ Never Married XX Married 1 ☐ Yes 2 Tho Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) JEAN BUDKA FRANK MAJESKY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GIDEON SERBU (HUSBAND) 105 Calverton Circle, Accokeek, MD 20607 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial Cremation 3 Removal from State 4 Donation 5 Other (Specify) CLINTON, MD LEE CREMATORY APRIL25, 2006 22. Name and Address of FacilityLEE FUNERAL HOME, 6633 OLD 21. Signature of Funer I Service Licensee M01461 ALEXANDRIA FERRY RD, CLINTON, MD 20735 00 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ck, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed: (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natura" --- any injury or other traumatic avairant.

Hospital or Attending Physician: The law requiras that the death certificate be executed

Examine physician and s the burial-transit Physician/Medical ٥ ģ Completed Be ဥ in by the funeral Certification:

certificate has

this

Director:

within 24 hours a

completely

death.

Division of Vital Records, P.O. Box 68760,

Immediate Ceuse (Final diseese or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 24a. Was an autopsy performed? 25 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2D No 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1∏Yes 2□No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physicien; To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. (Check only

who completed cause of death (Item 23a) (Type, Print)

1701 32 Registrar's Signature

ignature de la companya de la compan

State Registrar

Medical

29b. Signature and title of certifie

30. Name and address of persor

hysicia	_	1. Decedent's Name (First, Middle, Last) Emma_Sau	Her							2. Date of De	10, 200	Year	3. Time of Death
/Medic xamin		4a. Facility Name (If not institution, give s	street and numb	per)		4b. City,	Town, or	Location of	of Death	reprii	4c. Coun	ty of Deat	
		Johns Hopkins Bay				150		or	0411		N/		
neral ector		216-34-6221	M 25xF 7	. Age (In yrs.	Yrs.	If Under Months	Days	If Under	Min.	8. Date of Bird (Month, Da Feb. 1	4,1936	9. Birti Co Md	nplace (State or Foreig untry) •
=	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limit
or other traumatic event, the Medical Examiner must be notified at	ţō	Md. Baltim	ore		Eastwo	ood							1 ☐ Yes 2 🗖 N
a not	Funeral Director	10e. Street and Number	/			10f. Zip	Code				10g. Citizen of	What Co	untry?
diam	rail	7013 Conely St.			-		212				USA		
Dec	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deced Armed Ford	es?					gin? (Spo n, Puerto	ecify Yes or No Rican, etc.)	- 14. Ha	ack, White	rican Indian, e, etc.
TY D	þ	3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	es:		1 🗆 Yes	2X No	Specify:			Spec	ity: W	hite
100	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ition uring mosi	t of work	ing	16b. Kind of	Business/	Industry
9	du	Elementary/Secondary (0-12)	College (1-4	tor 5+)	life.	DO NOT us	se retired,)					
		12 yrs. 17. Father's Name (First, Middle, Last)			W	aitre	ess_	18. Mothe	er's Name	e (First, Middle,		ring	
	To Be	Frank Claridge						E	lizal	oeth F	rank	·	
		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Maili	ng Address	(Street a	nd Numbe	or Rura	al Route Numbe	er, City or Town	n, State, Z	Tip Code)
		Wayne Sautter	son		-		-	t. Ba	alto	. Md. 2	1224		
Suce.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	lemoval from SI	ate	Place of Dispo cemetery, crei	matory`or o	ther place			1 15,	20c. Location		Town, State
		4 □ Donation 5 □ Other (Specify)		Sac	red He			sus	_	2006	Dunda.	lk	
Suc		21. Signature of Funeral Service Licens	200							ne Of D			
		23a. Part). Enter the disease, or compli	cations that car	used the deat						Rd. 212 or respiratory ai			Approximate
an		shock, or heart failure. List only or Immediate Cause (Final	ne cause on ear UVEMI										Interval Between Onset and Death
al		disease or condition resulting in death)		r as a conseq	juence of):								1-1-1-1-1
r		Sequentially list conditions.	. End		Renal	DISC	asc						3 1 1115
	ine	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	1 as a 10 1 90	juence of):								,
	Examiner	that initiated events resulting in death) Last	Due to (o	r as a conseq	uence of):							_	
	cai		t										
	Medi						_						
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 Feta	I death 3	∃Ectopic pi						ate of del	ivery Day Year
	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unknov	nt at time of d vn	leath 5	Other (sp	ecify)						Duy Tour
		Part II. Other significant conditions cor	ntributing to dea	ith but not res	sulting in the u	inderlying c	ause give	n in Part I.		23e. Did t	obacco use co	ntribute ta	the cause of death?
	d by									10	Yes 2□No	3 ☐ Pr	obably 4 🗹 Unkno
İ	ompleted									24a. Was		. Were au	topsy findings availa
	E									autor perfo 1 ☐ Yes	rmed2	death?	completion of cause of
	BeC	25. Was case referred to medical examiner?							of Deat	h (Check only o			
	ဥ	1 □ Yes 2 ☑ No			ER/Outpatie			4 🗆 190	-	me 5□Resid			cify)
	ti Ou	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month)	Day Year)	28b. Time o Injury	M	8c. Injury Work	at ?? ∕es 2 🔲		28d. Describe l	now injury occi	Tued	
	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place o	of Injury - At h	ome, farm, st				Ī			nber or Ru	ıral Route Number,
	Cert	4 Homicide determined	building	g, etc. <i>(Specii</i>	<i>(y)</i>					City or To	wn, State)		
	dicai (29a. Certifier (Check only one)	sicism: To the to ner: On the bas and manne	sis of examina	wladge, dest ation and/or in	h seeuned vestigation	at the tin	ie, date an pinion, dea	d place, th occur	and due to the red at the time,	causu(s) and a date and place	and due	to the cause(s)
	Me	29b. Signature and title of certifier	4.10 114	1		290	c. License	number			29d. Date sign	ed (Monti	Con Year)
,		Dry Allicia	meo.	þ		K	FS-	000		-	Antil	10,	2000
		_ 11 . 10 1/0/1 4 10 /											

			1 - For State Registrar	State of M	arylan	d / Depa	artment rtificate	of He	alth ar		ital Hyg	iene	13133	
		yr.	Registrar 1. Decedent's Name (First, Middle, La	ist)			incate	OI D	calli	21	Date of Dea	eg. No.	3. Time of Death	
	Physici	an	JOSEPHINE	Y)	INA	SI	auter	3			Month	Day Year	101004	
- T	_/Medic		4a. Facility Name (If not institution, give				4b. City, To		ncation of		PRi]	25, 2006 4c. County of Dea	/	
	Examin	er	6222 SATIN	/ 1	RIVE	5	Col			Dodin		Howa		
190	Funeral					ast birthday)	If Under 1	Year I		4 Hrs. 8.	Date of Birth			
	Funeral Director			1□M 2XF	96	Yrs.	Months (Days	Hours	Min. M	Date of Birth (Month, Day)	orth ay, Year) 9. Birthplace (State or Foreign Country) 9. Germany		
	Usual Residence of Decedent									1110	11 0 17	, 1710 001		
	anylan ehow		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	e Ma	81	Maryland Howard		Co1	umbia							1 ☐ Yes 2 X No	
	or 28	Director	10e. Street and Number				10f. Zip C	ode			1	0g. Citizen of What C	ountry?	
	ath w		6222 Satinwood Dr				2104					USA		
	er de	une	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Deceder If Yes, specify	nt of Hisp / Cuban,	anic Origii Mexican,	n? (Specify Puerto Rica	Yes or No- in, etc.)	14. Race - Am Black, Wh		
36	'or	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	No		1 ☐ Yes 2【	□ No .	Specify:			Specify:		
8	hour	edt	15. Decedent's E			16a, Dece	dent's Usuat (Occupation	on			16b. Kind of Busines	nite Mindustry	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Iteme 23a or 28a-f ehow ha Madical Exarcher mout be notified at	Completed	(Specify only highest gr	ade completed)		(Give	kind of work DO NOT use	done duri	ing most o	of working		105. 11116 01 5451105	anadary	
212	iene iene the	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Homem	aker				and the state of t	Own Home		
	illed Hygi other	0	17. Father's Name (First, Middle, Las					18	8. Mother's	s Name (Fil	rst, Middle, i	Maiden Surname)		
lar	Aental Aental rked c	0	Frederich Schoenle					R	osina	а Меує	er			
Maryland	should and Men s marke umatic	y 3	19a. Informant's Name/Relationship	(Type, Print)								, City or Town, State,	Zip Code)	
	and 2 salth a n 27 i)	Katherine S. McCar	ter/daugh			Billow			lumbia	a, MD	21045		
ore	of He	11 22	20a. Method of Disposition	Demouslifeen State	20b. P	lace of Dispo	sition (Name	of er place)		April	26,	20c. Location - City o	r Town, State	
Ē	Pages nent of i		1 ☐ Burial 2 Y Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	JHemoval from State fy)	Ch		ke Cre			2006		eltsville,	, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "neturel", or Iteme 23s or 28s-1 ehow erry hipury or other traumatic event, if a Modical Erac insert must be inclined at any large.		21. Signature of Funeral Service Lice	9509/ //	/	22 G	Name and	Address	of Facility	ation	Servi	ce P.O. I	30x 784	
_	207		Bevef F	Helm	MO12	51 B	everly	L.	Heck	rotte.	P.A.	Clarksvil	le, MD 21029	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each l	d the death ine.	n. Do not ent	er the mode	of dying,	such as ca	ardiac or res	spiratory arr	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	20	cter	ial	Seps	Sis					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	_									
	Examine		Secuentially list conditions			ine	15						3 years	
V	sit sit	lhe	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	zence ot):								
10	be executed icien end burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):							-	
760,	eath certificate be executed ettending physicien end for use as the burial-transit	cai E				.,,								
687	# × 6			_ d										
Box (certif nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of de	alivary	
ă	Jeath etter	ciai	in the past 12 menths?	1□Live birth 4□Pregnant a			Ectopic preg Other (spec					Month	Day Year	
P.O.	the c y the achec	hysi	9 Unknown	9□Unknown										
	The law requires that the death certifica are has been signed by the etlending ph page 2 should be detached for use as th	by P	Part II. Other significant conditions	contributing to death I	out not resu	alting in the u	nderlying cau	se given	in Part I.		23e. Did tol	oacco use contribute	to the cause of death?	
ρ	w require been sig should b	ed	CHE	·							1 🗆 Ye	as 2□No 3□F	robably 4 Unknown	
Records,	aw re	piet	Service d	1501085	-						24a. Was a		ulopsy findings available	
ď	sician: The lav certificate has irector, page 2.	Completed									autops perform 1 Tes	ned? death?	completion of cause of	
Vital	Physician: this certificatal director, I	Be	25. Was case referred to medical examiner?					2	6. Place o		heck only on			
of V	> 07 77	ဦ	1 ☐ Yes 2 No	Hospital: 1 Inpati	ent 2 🗌	ER/Outpatier	t 3 DOA	Other:	4 🗌 Nurs	sing Home	5 Reside	ence 6 Other (Sp.	ecify)	
0	ding Phy h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of tnj (Month, Da	ury ay Year)	28b. Time of Injury	280	: Injury at Work?				ow injury occurred		
Sio	Attending in death. sector: After by the funer	cati	2 Accident investigation				М	1 🗌 Ye:	s 2 No					
Division	frect n by	ŧ	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	286. Place of in	jury - At ho tc. <i>(Specif</i> y	me, farm, str /)	eet, factory, o	office		28f.	Location (SI City or Town	reet and Number or F n, State)	Rural Route Number,	
	urs al aral D	ပိ		1										
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier 1 Certifying P (Cneck only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner s	of examinat	wiedge, deati tion and/or in	n occurred at vestigation, in	the time, my opin	date and ion, death	occurred a	due to the ci t the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)	
	ithin of the ormple	Mec	29b. Signature and title of certifier	and marrier s	tateu.		29c. l	_icense n	umber		2	9d. Date signed (Mor	th, Day, Year)	
\	F ≯ F ŏ		23	1	M	0		700	87 4	17	1	ADRIL 24	5,2006	
	σ_{\sim}		30. Name and address of person who	completed cause =	death (line	23a) /Tune		05	017		/	111110	7000	
	170			SET MO			Chari	eir	7-5	Tito 5	200	Columb	6,2006 a Md 21049	
. 0.54	Sta	te	31. Date filed (Month, Day, Year)	3 Regist	rar's Signa	ture				سرائب د		2000	~ 1-10 CIU44	
	Registr		APR 2 6 2	006 Mars	لكر ب	ture	ME							

	State of Maryland / Department of Health and M 1- State Registrer Certificate of Death	ental Hygiene 0 0 6	3134
Olympiaism.	Decedent's Name (First, Middle, Last)	Month Day Year	3. Time of Death
Physician /Medical	SARAH ANNE PATTEN SHEA	April 23, 2006	10:05 Å
Examiner	4a. Facility Name (If not institution, give street and number) BI_AKEHURST_HEALTHCARE_CENTER 4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore (County
Farena	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplac	ce (State or Foreign
Funeral Director	003-09-3322		Tampshire
P .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		. Inside City Limits
haryla ehov	Maryland Baltimore County Towson		1 □ Yes 2 No
28a-1	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country	?
death with the Maryland me 23e or 28e-f ehow rings be notified at meral Director	1055 West Joppa Road 21204	USA	
ifer death with the Ma	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - American Black, White, etc	
036 urs after alt, or its	1 Never Married 2 Married 1 Yes 2 No	Specify: Whi	te
tural tural		16b. Kind of Business/Indus	
21215-00 ed within 72 hou ygienen "natura ser than "natura ser than "natura ser than "catura ser than "catur	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0·12) College (1·4or 5+)		
212 ad with giene crth	12 Homemaker	Own Resider	nce
Maryland 21215-0036 at 2 should be litted within 72 hours aft and Mental Hygiene. 27 Is marked other than "natural", or recomments event, the Medical Exercitival and the properties of the Medical Exercitival Branch and To Be Completed by F	17. Father's Name (First, Middle, Last)	(First, Middle, Maiden Surname)	
ryla hould b d Ment marken natic	Peter Patten Bridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Pura		ode)
Mal ind 2 sl ith an 27 is r	Brendan D. Shea (Son) 177 Dumbarton Road, Ba		
Fe s 1 ar	20a. Method of Disposition 20b. Place of Disposition (Name of cameter, crematory or other place)	Date 20c. Location - City or Town	
Page nent o unt: If ury or	1 \(\subseteq \text{Burial 2 \subseteq Cremation 3 \subseteq Removal from State 4 \subseteq Donation 5 \subseteq Other (Specify) \subseteq \text{St. Mary's Ch Cemetery 4/2}	7/2006 Alexandria,	Virginia
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydrine. Important: If term 27 is marked other than "natural", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Experiment and the natified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Con Auron Mitchell-Wiedefeld Martin D. Lawson 6500 York Road Ba	Funeral Home, Inc.	21.2
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	Itimore, Maryland 21	pproximate aterval Between
Physician	shock, or near failure. List only one cause on each line. Immediate Cause (Final disease or condition	Ö	Onset and Death
/Medical	resulting in death) Due to (or as a consequence of):		N 4/3
Examiner	Sequentially list conditions. b. CCCCSBUASCULER CISERSE	7	ears
executed on and ital-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
60, be executed sicien and burial-transit	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
3760, ate be ex hysicien he burial	d.		
X 68° X certificat ding phy se as th			
. ^ ~ 63 6	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month D	ay Year
10:05 D.O. Bc at the death by the atter itached for t	1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify)		
- 5 6 5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	cause of death?
dS, P unites that usigned build be detailed by PP		1 ☐ Yes 2 ☐ No 3 ☐ Probab	oly 4 Unknown
Division of Vital Records, lor Attending Physician: The law requires faller death. In by the funeral director, page 2 should be entitlication: To Be Completed by		24a. Was an autopsy 24b. Were autops prior to comp	y findings available detion of cause of
I Rec		performed? death?	
Vital F	25. Was case referred to medical 26. Place of Death	h (Check only one)	
of Vital Of Vital Physician: rthis certifica	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	
On of holing Physics a funeral distribution: To	7 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe now injury occurred	
Vision Vision Attending r death. ector: After	2 Accident investigation 3 Suicide 6 Could not be determined determined 4 Discourage 28e. Place of Injury - At home, larm, street, lactory, office	281. Location (Street and Number or Rural F	Poute Number,
Division C Division C Spital or Attending P Tours after death. Tilled in by the Unerr al Certification:	4 Homicide building, etc. (Specify)	City or Town, State)	
Division Division Division To the Hospital or Attendit within 24 hours after death. To the Function Interctor: After the A	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as stat red at the time, date and place, and due to the	ted. he cause(s)
Nithin Co the complex	29b. Signature\and title of certifier 29c. License number	29d. Date signed (Month, Da	
6	Marling D 58303	APAIL 23 21	006
8	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON J. CHANCES, NO 6601 N. Charles St B.	somere us 21204	L.
State Registrar			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Marjory Custis Smith 24, 2006 April 5:05A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5800 Nicholson Lane, #1002 Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | January 29, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 86 577-24-8964 Yrs. Director Washington D.C Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Rockville Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Nicholson Lane #1002 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 XWidowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant Unisys 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ss 1 end 2 should be fis of Health and Mental H Item 27 te marked ot Inez Mae Custis Early James Bayard Gregg Custis III 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12813 Lake Wilderness Lane, Spotsylvania, VA 22553 Inez W. Wehrli / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If ites
eny Injury or ott April C 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium Inc Bethesda, Maryland 2006 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Robert A. Pum Bethesda-Chevy Chase Inc. 755 Bethesda, Maryland 20814-3501 Pumphrey Funeral Home/ 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final disease or condition resulting in death) **Physician** Gastric Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown this certificate has been signed by all director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 2 No et or Attending Physicien: T s atter death. Il Director: Atter this certificet of in by the funeral director, pa Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funerel C 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific April 25, 2006 D0062234 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manish Agrawal, M.D. 9707 Medical Center Drive, #300, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day April 16, 2006 Medical Examiner 0600 hrs Angela M. Santiago 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7 Harbor Tree Court Montgomery Village Montgomery 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Director Days Hours Country) Maryland 219-04-7381 1 M 2 X F 27 Usual Residence of Decedent illy. 10a. State 10c. City, Town or Location 10d Inside City Limits or 28a-f show Yes 2 X No death with the Maryland Maryland Montgomery Montgomery Village Director 10g. Citizen of What Country? 7 Harbor Tree Court 20886 United States 23а Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 8lack Armed Forces? 1 X Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes Widowed Divorced If Yes, Give Year Yes 2 X No specify. ş Specify White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done within 72 hours 16b. Kind of 8usiness/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than Baltimore, MD 21215-0036 ages I and 2 should be filed within nt of Health and Mental Hygiene.

1: If item 27 is marked other than other traumatic event, the Medion Compl Medical Receptionist Doctors Office 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) æ Jorge Santiago, Sr <u>Linda M. Cunningham</u> 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Shaw/ Mother iff Swallow Way Rockville, Maryland 20853 Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place)
Montgomery
Crematorium Inc 1 8urial 2 X Cremation 3 Removal from State Pages 1 April 20, 2006 Important: Department Donation 5 Other Specify Bethesda, Maryland 21 Signature of/Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Inc. 300 Maryland toMontgomery Avenue M00335 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure List only one cause on each line 8etween Onset and /Medical a Multiple Sharp Force Injuries Death Immediate Cause (Final disease [₹]xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of), certificate be executed Physician/Medical AMENDED item#19b,perFH,G855,5/4/06 TI physician at the burial -UNPENDED Box 68760. 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? ģ ۵. Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b Were autopsy findings available The law req autopsy prior to completion of cause of has performed? death? certificate h ector, page Yes 2 Yes 2 No 25. Was case referred to medica To the Hospital or Attending Physician: within 24 hours after death. 26. Place of Death (Check only one) Division of Vital Be examiner? Other₄ this Inpatient 2 Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 ٥ 1 V Yes 28a. Date of Injury (Month, Day Year) Apr 16, 2006 After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: within 24 hours arter www.

To the Funeral Director: A Subject was stabbed and cut Natural 0500 hrs 5 Pending 1 Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State) 7 Harbor Tree Court, Montgomery Village, MD (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) HD O.C.M.E. April 17, 2006 30. Name and address of person who completed cause of death (Item 23a) 5 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State 32. Redistrar's Signature APR Registrar

		•	For State Registrer	State of Ma	aryland / Depa <i>Cer</i>	artment of H <i>tificate of I</i>			ene () () 6	331
П			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic			Juan J.	Sanchez			Apri1	,	6:06 PM M
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
				Hospital	de la trabiat de la		Bethesda If Under 24 Hrs.	a Barant Birth		tgomery
	Funeral		5. Social Security Number 6. Security Number 1.2	k 7. Age IM 2□F	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign buntry)
	Director		231-96-3818 Usual Residence of Decedent		65 trs.			July 12	, 1940	Spain
pue	* ==		10a, State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Na Se	- 3	ţō	Maryland Monte	omery		R	ockville			1 ☐ Yes 2 🎇 No
ŧ.	28 and 18	Director	10e, Street and Number	omery		10f. Zip Code	DCRVIIIC	10	0g. Citizen of What Co	ountry?
i.i.	8 4		5901 Montro	se Road N	204		20852		United	States
100	Ē	ner		12. Was Decedent E Armed Forces?		Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
2 4	1 1	by Funeral	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 📉 N If Yes, Give	10	1 ☐ Yes 2X No	Specify:	Tilodii, Gio.)	Specify:	0, 610.
G K I K I C-10000	and Manial Hygiene. Is marked other than "natural", or itama 23e or 28e-f ahow eumatic event, the Midical Examinar must be notified at		3 Widowed 4 Divorced	Year or Dates:						White
5 8	dice	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ang	16b. Kind of Business	Industry
7	hen.	m	Elementary/Secondary (0-12)	College (1-4or 5	i+)		_		Cate	ring
ע קל ק	Hygie nt, II		17. Father's Name (First, Middle, Last)	4		Che	18. Mother's Nam	e (First, Middle, N		IIIIg
	ed o	Be	12 = 30300	Sanchez-G	ongolog		Fulla.	lia Sana	hez Ponga-	Cuesta
ar yrain	mark matter	ဥ	19a. Informant's Name/Relationship (7)			ng Address (Street			City or Town, State,	
, ma	Ith ar Ith ar 27 ta 1 trau		Pino P. Sanchez/		5901	Montrose	Road N20	4. Rocky	ille. Marv	land 20852
י ע	tam t		20a. Method of Disposition	WIIC	20b. Place of Dispo				20c. Location - City or	
2	nages nent of I nnt: If tt		1 ☐ Burial 2 【【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Montgo		Ap:	ril 2006	Rethesda	, Maryland
	. 등문송		21. Signature of Funeral Service Licens		CI ellia LC	2. Name and Addre	ss of Facility Rob	ert_A. I	umphrey Fu	ineral Home/ onsinAvenue
Ď	Depe Impo		Ven 2	should !	M00335 B	etnesda-C ethesda.	nevy Chas Maryland	se, inc. 20814-35	/55/ Wisc 501	onsin Avenue
			23a. Part1. Enter the disease, or composition shock, or heart failure. List only o	lications that caused	the death. Do not ent					Approximate Interval Between
P	hysician	5 W	Immediate Cause (Final disease or condition		Valve End	ncarditie				Onset and Death 2 Weeks
	/Medical		resulting in death)		a consequence of):	ocararere				2 110000
	xaminer		Sequentially list conditions,	b						
A	2 %	Ine	cause. Enter Underlying	Due to (or as	a eurisaquenes ut):					
1	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
ה מ	icate be executed physicien and s the burial-transit									
00/00		edical		d.					j. j	
	oerill Se as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
מ מ	etter d for c	ician/M	in the past 12 months?	4☐Pregnant at		⊒Ectopic pregnanc; ⊒ Other (specify) _	<i>y</i>		Month	Day Year
j ,	w requires marrine deain cerni been signed by the ettending should be detached for use a	hys	9 Unknown	9□ Unknown	_					
, ·	ned h	by P	Part II. Other significant conditions co	ntributing to death b	out not resulting in the u	inderlying cause giv	ren in Part I.	23e. Did tot	pacco use contribute to	o the cause of death?
ğ	an sig		Isch	emic Card	<u>iomyopathy</u>			1 ∑ Y€	es 2□No 3□P	robably 4 ∐Unknown
Vital Records,	m so	Completed	End-Stage Re	nal Disea	se on Hemo	dialysis		24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
ř	sician: The law certificate has b irector, page 2 sf	ě						perforr 1 ☐ Yes	ned? death?	5 2 □ No
<u>.</u>	ysician: is certifica director, I	Bec	25. Was case referred to medical examiner?					th (Check only on		
	× 8 9	2	1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatie			4 Norsing I		ence 6 Other (Spe	ecify)
	و آج و	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	Wo		28d. Describe ho	ow injury occurred	
S	5 5 6 5	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	OOL Leasting (C)	total and Mombas as C	hard Courte Manning
DIVISION	a or Attendar attar deeth. I Diractor: A d in by the fu	Certification:	4 Homicide determined	289. Place of In	jury - At home, farm, st ic. (Specify)	reet, raciory, office		City or Town	treet and Number or R n, State)	urar moute ivumber,
	pltal		29a. Certifier 1X Certifying Phy	sicien: To the best	of my knowledge, deal	th occurred at the ti	me date and place	and due to the c	ause(s) and manner a	s stated.
	24 h 24 h Fun ately	Medicai			f examination and/or in					
	To the Hospital or Atti within 24 hours attar de To the Funeral Direct complately filled in by the	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
,			Michael a. ?	Western	an, M.D.		D52451		April 1	8. 2006
	Gi		30. Name and address of person who o		1	Print)	DJ24J1		Whili I	2000
	1,		Michael A. Weste	rman, M.D	. 8600 01	d Georget	own Road	Bethesda	a, Marylan	d 20814
		ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	osele			-	
	Regist	rar	APR 2 6 Z	UUD JOSE	4 14 19					

4/18/06 6:06 PM

Juan Sanchez

					denoie iik. Ensure	-	
			For State Of N		rtment of Health and tificate of Death	,	11116 13133
			Registrar	Cert	inicale of Dealif	Reg. #	
4	Physici	an	1. Decedent's Name (First, Middle, Last)	ZULCZEU	15/2 2A		Pay Year 3. Time of Death
	/Medic	al				Nor! F	1006 J./S (M
	Examin	er	4a. Facility Name (If not institution, give street and number MEOICA)	do well	4b. City, Town, or Location of De	A 15	San Late Man 15
				ge (In yrs. last birthday)	If Under 1 Year If Under 24 H	rs. 8. Date of Birth	9. Birthplace (State or Foreign
*	Funeral Director		216-28-3808 ^{1□M 2} ▼F	74 Yrs.	Months Days Hours Mi	rs. 8. Date of Birth (Month, Day, Yea 11/3/31	Country) Maryland
Vr	2		Usual Residence of Decedent			111/5/51	Haryrand
	ours after death with the Marylan rel', or iteme 23a or 28a-f show Examiner must be notified at		10a. State 10b. County	10c. City, Town or Loc	ation		10d. Inside City Limits
	B Ma	Funeral Director	Md n/a	Balti	more		1 ⊠Yes 2 □ No
	or 26	Oire	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	23a	ra	1351 S. Clinton St.		21224		USA
	te me	nue	11. Marital Status 12. Was Deceder Armed Force:	5? If	as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or l	Ϋ́F	1 ★ Never Married 2 Married 1 → Yes 2 ▼ 3 → Widowed 4 → Divorced Year or Dates	1	☐ Yes 2 No Specify:		Specify:
21215-0036	72 hours after death with the Maryland "neturel", or Iteme 23a or 28a-f show officel Exercine from the notified at	Completed by	15. Decedent's Education		ent's Usual Occupation	16h	White Kind of Business/Industry
15	be filed within 72 ho ntal Hygiene. od other then "netur event, tre Medical	olet	(Specify only highest grade completed)	(Give k	kind of work done during most of w O NOT use retired)	vorking	Kind of Eddinosa industry
112	within iene.	mo	Elementary/Secondary (0-12) College (1-40		eamstress		Clothing
	I Hygir other	Be C	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	
<u>a</u> n	should be id Mental marked c	To B	John Szulczewska		Berth	a Poniato	wski
Maryland	2 should and Men is marke sumatic	. 4	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street and Number or	Rural Route Number, Cit	y or Town, State, Zip Code)
_	25 E E		Cheryle Szulczewski	3126	Elliott St.	Baltimore	Md. 21224
ē,	es 1 ar of Hea fitem r other	1	20a. Method of Disposition	20b. Place of Dispos			Location - City or Town, State
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ej	Cemetery 4/2	8/06 Ba	ltimore, Md.
alt:	permit. Pag Department Importent: Imy njury o		21. Signature of Funeral Service Licensee		Name and Address to Facility or		
ä	Den den yen		Eugene Last	12	01 Dundalk Av	e. Baltim	ore, Md. 21222
Ļγ			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not ente	r the mode of dying, such as card	ac or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	25 75			Onset and Death
	/Medical		resulting in death)	is a consequence of);		0 1	3 37193
1 6	Examiner	î.	Nem	ophilis	Influenz	A BACTE	Vem MA 3 CKGF
		her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of):			
1	and L-transi	Examiner	that initiated events	TE NON	DOWAVE	Myocard	1A/ 3 dx 45
0	ie be executed ysician and e burial-transit		resulting in death) Last Due to (or a	s a consequence of):	() =	INFUVC	NOW
3760	ate be ex nysician he buria	Icai	(d.CON	EZVIVE	Neart FI	RILUYE	30475
.89	Physician: The law requires that the death certificate to this certificate that been signed by the attending physical director, page 2 should be detached for use as the trial director.	Physician/Med	IF FEMALE:				
Вох	th ce	an/	23b Was decedent prograph 23c. If yes, outcon		Ectopic pregnancy		23d. Date of delivery Month Day Year
	the all	sici	1 Yes 9 No 9 Unknown	at time of death 5	Other (specify)		World Day Toal
P.0	that the de ed by the detached	Ph.	Part II. Other significant conditions contributing to death	h. 4 and	de hije e e e e e e e e e e e	OZa Did tabasa	o use contribute to the cause of death?
ŝ	ires tha signed d be det	þ	END STAGE NEWY	4			2 No 3 Probably Winknown
oro	w require been si should I	ted			7	- 103	2 No 3 Flobably 4 Conkilowi
ec	e 2 si	Completed	Crescent 61	prerulo	nepukivis	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E H	The cete l	ပ္ပ	A PARTIE AND A PAR		•	performed	
Vital Records,	eician: The law certificete has b irector, page 2 s	Be	25. Was case referred to medical examiner?			eath (Check only one)	
of	this day	J.	To res 2 pro			Home 5 Residence	
u C	Jing I	io	1 Natural 5 Pending (Month, I	jury 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred
isi	death death tor: / the	ical	2 Accident investigation 3 Suicide 6 Could not be	njury - At home, farm, stre		28f Location (Street	and Number or Rural Route Number.
Division	after Direction by	Certification:	4 Homicide determined 289. Place of building,	etc. (Specify)	ot, ractory, office	City or Town, St.	are)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerat Director: Atter this certificate ha completely filled in by the funeral director, page		29a. Certifier (12 Certifying Physician: To the be	st of my knowledge, death	occurred at the time, date and pla	ce, and due to the cause	(s) and manner as stated.
	e Hos	Medical	(Check only 2 Medical Exeminer: On the basis and manner	of examination and/or inve	estigation, in my opinion, death oc	curred at the time, date a	and place, and due to the cause(s)
	rothin Forthin compl	Me	29b. Signature and ma of centring		29c. License number	29d. I	Date signed (Month, Dey, Year)
				- n	15036	1	11/21/1000
	10		30. Name and address of person who completed cause o	death (Item 23a) (Type, F	Print)	- Marie	4,005 MD 2005
	10		JUNT BON ACEN.	MP 2015	Print) TPAURPL	BultIn	WOUS MD HINE
5	Sta	ite	31. Date filled (Month, Day, Year) 32. Regis	trar's Signature	,		
	Regist	ar	APR 2 6 2006	K Goods	1		

		For State	State	of Marylar						lental Hy	giene	nne		3139
		Registrar 1. Decedent's Name (First, Middle	a Land		Cei	tificate	or L	Jeath		2 Date of De	Reg. No. of Death 3. Time of Death			
Physicia	n		,							Month	Day	Ye	ar	ime of Death
/Medica		BARBARA 4a. Facility Name (If not institution	THOMPS			4b. City, T	-OWED OF	Location	of Donth	APRIL	25	200 County of D		55 A ^m
Examine	i				A D.F.			Location	OI Death			,		
Funeral		GILCHRIST CENT 5. Social Security Number	6. Sex	7. Age (In yrs.		TOWS		If Under	24 Hrs.	8. Date of Bir		ALT IM	-0112	State or Foreign
Director		219-50-6377	1 □ M 2 🛣 F	55	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 8-26-	y, Year) -1950		Country)	MD
P		Usual Residence of Decedent												
ahow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation								ide City Limits
r 28a-f ahow	Sch		TIMORE		TURNERS	-1								Yes 2 □ No
vith th	Director	10e. Street and Number				10f. Zip (en of What	t Country?	
death with the Marylend ms 23s or 28s-f show trivial be rediffed at	a.	127 CARVER ROA					21222					USA		
	Funeral	11. Marital Status	Armed F			Mas Decede f Yes, speci	ent of His ty Cubar	spanic Or n, Mexicai	n, Puerto	ecify Yes or No Rican, etc.)	- 1		American Indi Vhite, etc.	an,
	by	3 Widowed 4 Divorced	If Yes G	2∕0XNo live Dates:		Yes X	X No	Specify:	:			Specify:	BLACK	
2 hou		15. Deceden	t's Education		16a. Deced	lent's Usual	Occupa	tion			16b. Kir		ess/Industry	
filed withIn 72 Hygiene. Ither then "nei ent, I'm Medig	Completed	(Specify only highe Elementary/Secondary (0-12)	T	(1-4or 5+)	(Give	kind of work DO NOT use	done di	uring mos	t of work	ng			,	
d with	E	Elementary/Secondary (0-12)	4	(1-401 5+)	l l	IURSE					Н	EALTH		
N S E H	Be	17. Father's Name (First, Middle,	Last)					18. Moth	er's Name	(First, Middle,	Maiden :	Surname)		
Ments Ments arked	0	LAWRENCE THOMP	SON		*)A#(Hart		MAR	RGUER	ITE SM	TH			
2 should be filed withli and Mental Hygiene. Is marked other than sumatic event, Ita M	1	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address	(Street a	nd Numb	er or Rura	I Route Numbe	er, City or	Town, Stat	te, Zip Code)	
and ealth m 27 har tr	-	AGNES M. HOLME	S/SISTER	1001.0		RUTH		NUE		IMORE,			21219	
permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any Injury or other treumatic e <u>poce</u> .		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cometery, cren	sition (Nami natory or oth	e of her place)	L	Date	20c. Loc	ation - City	or Town, Sta	ate
tmen tant:		4 Donation 5 Other (S		BA	LTIMORE	E CEME	TERY	Y	4-28	-2006	BAL	TIMOR	E, MAR	RYLAND
Departit. Departit Import		21. Signature of Funeral Service	Licensee	-						ES A. N	ORTO	N & S	ONS F.	H., INC.
40240		James	4. 1/je	non		701-31						, MAR	YLAND	
		23a. Part. Enter the disease, or shock, or heart failure. List	only one cause on	each line.	h. Do not ente	er the mode	of dying	, such as	cardiac c	r respiratory a	rrest,		Interv	ximate al Between and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Ch	ronic	0551	ruct	rice	Les	no	disen	150			AVS
/Medical Examiner		rosaling in doality	Due to	(or as a conseq	uence of):				/				0	
1.	2	Sequentially list conditions,	b. — Due to	(U) as a Cuffs@Q	uence on									
nslt	Ē	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S											
executed and and ial-transl	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								_	
bur icia	dicai		d.											
= 00	a													
eath certific attanding p	Sup.	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Peta		Ectopic pre	ananev				2	3d. Date of	,	
ed to	SICI	in the past 12 months?		nant at time of d		Other (spe						Month	Day	Year
of the de	Physician/M	9 ☐ Unknown								T				
res the igned I	2	Part II. Other significant condition	Arter-	./		nderlying car	use give	n in Part I	l.				e to the caus	
w require	ed		1/4/0/5	/ 0/30	7/30					1787	res 2L]No 3□] Probably	4 Unknown
e law	Completed		 							24a. Was autor	sy	prior	to completion	tings available n of cause of
										1 Tes	rmed? 2 No	death 1 🗆 Y		
centif	Be	25. Was case referred to medica examiner?	Hospital				Othe			Check only o		. /	11	
this ald	0	1 Yes 2 No	28a. Date		ER/Outpatien 28b. Time of		,	7		ne 5 ☐ Resid 28d. Describe I			Specity) #25	pice
ding th. fune	5	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	g (Mo	nth, Day Year)	Injury	М	c. Injury Work	? ′es 2 🔲		200. 0030100	ion injury	Socurrog		
Atten deal octor	1ca	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At ho	ome, farm, stre	l				28f. Location (S	Street and	Number or	r Rural Route	Number.
a after	Certification:	4 Homicide determ	buile	ding, etc. (Specif	y)					City or Tov	vn, State)			
Hospital or Attending Physicien: 44 hours after death. Funerel Director: After this certificiely filled in by the funeral director.		29a. Certifier 1 Certifyir (Check only 2 Medical	g Physician: To th	e best of my kno	wledge, death	occurred a	t the time	e, date an	nd place, a	and due to the	cause(s)	and manner	r as stated.	
To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai	one)	Examiner: On the and ma	nner stated.	ition and/or inv	estigation, i	in my opi	inion, dea	ath occurre	ed at the time,	date and	olace, and	due to the ca	use(s)
To T Com	2	29b. Signature and title of certifie	4	1	0	29c.	License	number			29d. Date	signed (M	onth, Day, Ye	ear)
ih		10	hy le	ey, "	ره	1) 2.	5 2	27		uthe	71.	23,2	2006
18		30. Name and address of person		use death (Iten	n 23a) (Type, I	Print)	h.	le	51.	Bal	to.	med	2120	25
State	0	31. Date filed (Month, Day, Year)	1xy 6-9	Ragistrar's Signa		1: -	- 05-							/
Registra		APR 2		Marine		A R	,							
		111117	LUUU A	The state of the s	63° E83	23-36								

		1 - For State Registrar	State	of Mai	ryland	-	rtment tificate			and M	ental Hy	giene Reg. No.	006	131	40
		1. Decedent's Name (First, Middle,	Last)	,							2. Date of D	eath Day	Year	3. Time of	_
Physicia /Medic		Edward		ette							April	24	2006	743	3 A M
Examin		4a. Facility Name (If not institution,	give street and	number)	, 1. ,		4b. City, 1		,	of Death		4c. 0	County of Death		
		5. Social Security Number	ise Of Sa 6. Sex	try H.	10 400 100	st birthday)	If Under		If Under	24 Hrs.	8. Date of B	irth	Buth.	place (State o	r Foreign
Funeral Director			1.X2M 2□ F	=	(111 yrs. 14s 7 7	Yrs.	Months		Hours	Min.	12/05	ay, Year)	Cot	cyland	, o. o.g.
		345-24-2944 Usual Residence of Decedent									12/05/	1920	Maj		
laryland show		10a. State 10b. County			10c. City,	Town or Lo	cation							10d. Inside Ci 1 ☐ Yes	_
the Ma 28a-f s	cto	MD Balti	more		Balo	dwin									
ith th	Director	10e. Street and Number					10f. Zip						en of What Cou	intry ?	
s 23a		2855 Green Roa		ecedent E	ver in II S	13 \		013	snanic Ori	igin? (Spe	cify Yes or N		S.A. 4. Race - Amer	ican Indian.	
ter deal	Funeral	11. Marital Status 1 X Never Married 2 Marrie	Amed	lForces? es 2 ⊟ No	D	1					cify Yes or N Rican, etc.)		Black, White	, etc.	
itied within 72 hours after death with the Maryland Hygiene. Ather than "natural", or items 23e or 28e-f show after than Institute I and a final tean chiling I am in the I and I am in the I am I am I am I am I am I am I am I a	by	3 Widowed 4 Divorced	If Yes, Year o	es 2 No Give 1 S or Dates: 1	955- 975	1	I□Yes 2	! ∭ No	Specify:				Specify: Wh	ite	
72 ho	Completed	15. Decedent' (Specify only highest	s Education	ed)		16a. Deced	kind of wor.	k done di	uring mos	t of worki	n <i>g</i>	16b. Kin	d of Business/I	ndustry	
Men ithin	nple	Elementary/Secondary (0-12)	1	e (1-4or 5+	-)	life. L	DO NOT us	e retired)							
led w tygier ther th	ဒီ	12 17. Father's Name (First, Middle, L	aeti	10		Ento	molog		18 Mothe	er's Name	(First, Middl		Air Fo	rce	
tal H	Be			11.									·		
an y latter to the state of the	ဥ	Chester Courtne		tte		19b. Mailin	ng Address	(Street a			maline Route Num		Town, State, Z	ip Code)	
ie, wan y land Z iz iz z	ĺ	John J. Baker,		nusin		9023	01d F	Jarfo	ord R	oad -	- Balt	imore	, Maryl	and 2	1234
s 1 and 3 if Health Item 27 other tr	-	20a. Method of Disposition			20b. Pla	ce of Dispo	sition (Nam	e of			ate		cation - City or		
Page C		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		om State		dwill	-			04/2	8/2006	Fall	ston, M	arvlan	9
permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service L	icensee				. Name an						Funeral		
0 88589		16.50	asses	in						ad -	Kings	ville	, Maryl	and 2	1087
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications the	at caused to on each line	the death. e.	Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory	arrest,		Approximat Interval Bet Onset and I	ween
Physician		tmmediate Cause (Final disease or condition	_ a C	homis	01	ozm	chie	Pu	Imo.	non	Z D	seens	2		
/Medical Examiner		resulting in death)	Due	to (or as a	conseque	ence of):)				
	20	Sequentially list conditions, if any, leading to immediate	b. Due	io (or as a	Conseque	atice of).									
uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
be executed icien and burial-transit	Exa	resulting in death) Last	C. Due	to (or as a	conseque	ence of):									
s ys	Ical		d												
certifica ding ph	Physician/Med	IF FEMALE:													
death ce	lan/	23b. Was decedent pregnant in the past 12 months?	1 🗀 Li	outcome o	2 Fetal o	death 3	Ectopic pr					2	3d. Date of deli Month	-	Year
. 5 0 5	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		regnant at t nknown	time or dea	atn 5L	Other (sp	өспу)							
The law requires that the law requires that the law seen signed by the lagge 2 should be detached.	F.	Part II. Other significant condition	ns contributing	to death bu	it not resul	ting in the u	nderlying c	ause give	en in Part I	1.	23e. Dio	tobacco u	se contribute to	the cause of c	leath?
wrequires that been signed be should be defi	d by	Alzheiner	- Dem	entra							10]Yes 2[□No 3□Pr	obably 4	Jiknown
HECOLOR he law requir hes been si ige 2 should I	lete										24a. W		24b. Were au	topsy findings completion of a	available
The lav	Completed											opsy formed? 2 2 No	death?	10	ause of
	Be C	25. Was case referred to medical	-)\c)						26. Place	e of Death	(Check only		1		
Q 5 0	70	examiner?		l 🗌 Inpatier		R/Outpatier			4 114		me 5□Re		Other (Spec	CITY) ALF	-
	ino ::	27. Manner of Death 1 State ral 5 ☐ Pendin	9	ate of Injur Month, Day	Year)	28b. Time o Injury		8c. Injury Work			28d. Describ	e how injur	ccurred		
VISIO Attendi	cat	2 Accident investig	not be	llace of Iniv	nu - At hor	me, farm, sti	M factor		Yes 2□		28f Location	(Street and	d Number or Ru	ıral Route Num	nber
DIVISION or Attending after death. Director: Afte	Certification:	4 Homicide determ	ined 200. F	uilding, etc	: (Specify))	reet, ractory	, onice				own, State,			
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune			g Physician: To												
n 24 h n 24 h ne Fu oletely	Medical	one)		he basis of manner sta		on and/or in				ath occurr	red at the tim				·)
To the within 2 To the complet	×	29b. Signature and title of certifier					- 1		e number				e signed (Monti		
		Miles	-	1				770	594	23		Ap	ril 24	2006	
10x1		3) Name an address of pers			eath (Item	23a) (Type,	Print)	Dir	2atan		> //		ri/24	11.39	
1071	ate	31. Date filed (Month, Day, Year)		1 LUC 32 Registra	ar's Signati	aven ure	BIVI	1-01	J7230	S):	Saltin	we	1000	125/	
Regist		APR 2 6	2006	Conn	. 1	S AS	MES								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 09:19 AM APRIL Thompson 21 2006 Henry Edward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year)
June 2, 1942 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1**X** M 2□ F Months 63 053-32-9678 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Towson Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21204 8415 Bellona Lane #316 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Specify White ģ Year or Dates: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Salesman other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be i. Pages 1 and 2 should be fill then of Health and Mental H tant: If item 27 is marked ott jury or other traumatic even Burdella Egeland Claud Vernon Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7109 Heathfield Rd. Baltimore, MD 21212 Allison T. Watkins/daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 04/25/06 Beltsville, Maryland permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Feckrotte, P.A. Clarksville, ND 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A cute Myocarded Infarction 0 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, physicien Be Completed by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year Day ŏ 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the sideland P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2, No 1 Yes 1 ☐ Yes Division of Vital After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 Ploutpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 2 ☐ Accident Certification: 5 Pending after death.

Director: All
d in by the fur 1 Tes 2 No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funaral C filled Hospitel 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier april 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1601 OSLER DRIVE TOWSON MARYLAND 2/204 M.D. GAIL P. CUNNINGHAM 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

06-02707	
Edward Vaughn	

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 21, 2006 **Medical Examiner** Edward Ray Vaughn 1310 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Landsdowne **Baltimore County** 4103 Hollins Ferry Road If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs last birthday) 8. Date of Birth (MM/DD/YYYY) 9 8 irthplace (State or **Funeral** 217-78-7993 Months Days Hours April 7,1962 Director 44 Country) 1 X M 2 F Usual Residence of Decedent 0b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Baltimore Lansdowne Yes 2 X No 28a-f shov hours after death with the Maryland fied at once Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 4103 Hollins Ferry Rd. 21227 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black 1 Never Married 2 Married Armed Forces White, etc. 2 X No Yes Specify White f Yes, Give Year 1 Yes 2 X No specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) es I and 2 should be filed within 72 h of Health and Mental Hygiene 27 is marked other than 'matic event, the Medical MD 21215-0036 12 4 Electrician Electricial 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Carlos Vaughn Freda J. Honaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45 Stone Drive Pasadena, MD 21122 Michele L. Vaughn/Wife If item 2 ther traur 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pages 1 Glen Haven Department or Important: I Memorial 04-26-2006 Glen Burnie, MD Donation 5 Other Specify 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 21. Signature of Funeral Service Licenses M or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I Enter the disease, **Physician** failure. List only one cause on each line 8etween Onset and /Medical Death Immediate Cause (Final disease Hypertensive atherosclerotic cardiovascular disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical item#23a,27,perME,g855,5/1/06 TI X UNPENDED attending physician or use as the burial -AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 page 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ۵ 1 🗸 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d Describe how injury occurred Certification: X Natural 1 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E April 22, 2006 M0 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

ÖRIGINAL

		1	For State Registrar	State of Marylan		artment of rtificate o		Re	g. No. UU b	13143
	Physici	an	1. Decedent's Name (First, Middle, Las Douglas Arthur					2. Date of Death Month April 19	Day Ye	3. Time of Death 9:30 A M
	/Medic	8.4	4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Dea		4c. County of D	
	Examili	er	5550 Southwest			A:	rbutus		Ba1	timore
	Funeral Director		214-44-4922	9x 7. Age (<i>In yr</i> s. ▼ M 2□ F 61		If Under 1 Ye Months Day			, 1944 9.	Birthplace (State or Foreign Country) Pennsylvania
	and	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation	-			10d. Inside City Limits
	Maryl Ifed	tor	MD Bal	timore		Arbut	ıs			1 ☐ Yes 2▼ No
	ith the	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What	
	e 23a	rai	5550 Southwester	n Blvd. 12. Was Decedent Ever in U	c 13	Was Decedent	21227	Specify Yes or No-	United S	Tates
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Itame 23a or 28a-f show any Injury or other traumatic event, the Modral Exphiract unit be notified at once.	by Fur	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify C	of Hispanic Origin? (: uban, Mexican, Pue No <i>Specify:</i>	to Rican, etc.)	Black, W	White, etc. White
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Oc	ne during most of wo		16b. Kind of Busine	,
12	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Spe	cial Eq			Motion Producti	Picture
0	filed v Hygie Sther I		17. Father's Name (First, Middle, Last)			Opera		me (First, Middle, M		.011
Maryland 21215-0036	Aental Aental rked c	To Be	Charles Walk				Yo	Landa Leas	sure	
lary	and h		19a. Informant's Name/Relationship (lural Route Number,		
	1 and Health em 27 ther tr		Karen A. Walk W:	ife 20b.F	Place of Dispo	osition (Name of		Lvd, Arbut	CUS, MD 2 20c. Location - City	
nor	ages int of l t: If It		1 Burial 2 Cremation 3X 4 Donation 5 Qther (Specific	Removal from State	cemetery, cre	matory`or other ; .orial P:	olace)	4-2006 A	Altoona,	ΡΔ
Baltimore,	nit. Partme sortan Injuri		21. Signatur of Funeral Service Licer					rose Fune		
ä	Depa Impo any I		Jun Do	XJUIL EOO	2010			Rd., Arl		
68760,	Physician /Medical Examiner the pnual-transit	dicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Ons tand Death 2005 WALUAC					
.O. Box (The law requires that tha death certifica ate has been signed by the attending ph page 2 shouid be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o	al death 3[⊒Ectopic pregna ⊒ Other (specify			23d. Date of Month	delivery Day Year
<u>α</u>	uires that (signed by Id be deta	ρ	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	inderlying cause	given in Part I.	23e. Did tob	1	te to the cause of death? Probably 4 Unknown
Vital Records,		Completed						24a. Was a autops perform 1 \sum Yes 2	y prior	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath (Check only on		
ŏ	ding Phys I. After this funeral dis	tion: To	1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. I	njury at Work?	28d. Describe ho	ow injury occurred	Specify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte complately filled in by the fune	Certification:	3 Suicide 6 Could not b	B 280 Place of Injury - At h	nome, farm, st	reet, factory, off	ce	28f. Location (St City or Town		or Rural Route Number,
	ne Hospital or Ain 24 hours after (edicai (29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of my kn miner: On the basis of oxamin and manner stated.	owledge, dea ation and/or in	th occurred at the	e time, date and plainy opinion, death oc			
	To the P within 2. To the Complate	Ž	29b. Signature and title of certifier	0			ense number	2	9d. Date signed (A	
)	1		Mais of the	rentz			28768		4/20	
1	U		30. Name and address of person who HANO ELECTION STENG	completed dause of death (ite	M (EAN	S STAKE	T IMSI	BAUTITO	RE, Mol	21231-1000
Total Section	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 6 2	32. egistrar's Sign	ature A	oute				

		1 - For State Registrar	State of I	Marylan		artment tificate			nd M		jiene	6	3
Physic	ian	Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	Day	Year	3. Time of Death
/Med	ical	Melvin J. Wengert 4a. Facility Name (If not institution, give		orl		4h City T	Tourn or	Location of	Dooth	April	24, 200 4c. County		8:40P M
Exami	iner	8331 Elvaton Rd	Street and numb	91)				ville	Deam		Anne A		
Funera		5. Social Security Number 6. Se		Age (In yrs.	last birthday)	If Under 1	1 Year	If Under 2		8. Date of Birth (Month, Day			nplace (State or Foreign untry)
Director		213-03-7705	□M 2□F	92	Yrs.	Months	Days	Hours	Min.	Sept 14	, 1913	Cou	MD MD
and		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
Mary -1 sho	ţō	MD Anne Arun	dol	M-	illersv	71110							1 ☐ Yes 21 No
h the or 28e	lrec	10e. Street and Number	der	ri.	TITELS	10f. Zip (Code			1	0g. Citizen of V	Vhat Cou	untry?
ath with	Funeral Director	8331 Elvaton Rd				2	2110	8				USA	
tams	nuel	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13. \	Was Decede f Yes, speci	ent of His fy Cubar	spanic Orig n, Mexican,	in? (Spe Puerto I	cify Yes or No- Rican, etc.)		e - Ameri k, White,	rican Indian, o, etc.
rs after	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√ If Yes, Give Year or Date	e. E¥yo		∏Yes 2	∏ No	Specify:			Specify	τ.πh	nite
2 hou		15. Decedent's Ed	ucation		16a. Deced	lent's Usual	Occupa	tion			16b. Kind of Bu		
6. re n n n n n n n n n n n n n n n n n n	Completed	(Specify only highest grad	de completed) College (1-4)	or 5+)	(Give life. L	kind of work DO NOT use	k done di e retired)	uring most	of workii	ng			
led will ygien har th		6			F	oremar					Traile).
yiallia KIKIDOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	Be	17. Father's Name (First, Middle, Last)									Maiden Sumam	Θ)	
2 should be and Mental is marked commetic even	ပ္	Frederick Wengert 19a. Informant's Name/Relationship (7			19b. Mailin	a Address	(Street a			kocil	, City or Town,	State Zi	in Code)
2 p < > > =		Nancy Ann Smith	Daughte	er	262 8	-						3,210, 20,	<i>-</i> 0000,
Datainore, M permi. Pages 1 and 2 Department of Health Importent: if item 27 any injury or other tra		20a. Method of Disposition		20b. P	Place of Dispo- emetery, cren	sition (Name	e of her place)	D	ate	20c. Location -	City or T	own, State
mit. Pages partment of portent: if it y injury or o		1 Burial 2 Cremation 3 □ 1 Donation 5 Other (Specify		110	n Havei	n Ceme	eter	y 4	-28-		Glen Bu		, MD
Dant. Depart		21. Signature	*		22	ame and	Address	s of Facility	ome.	P.A.	nie, MD		0.64
00500		Gregory Fink	1	01148								21	.061
31		23a. Part Enter the disease or comp shock or heart failure. List only of Immediate Cause (Final		1	,	er (tie mode	or dying	, such as c	ardiac o	respiratory arri	est,		Approximate Interval Between Onset and Death
⊢rnysician /Medical	_	disease or condition resulting in death)		nevit as a conseq					_			-1	lyear.
Examiner			A 80	カマル	hor	1 /	ma	ein	2	u ia			4-6-06
₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (as a conseq	uence of):	1							
ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	a E		Due to (or	as a conseq	uence or):								
ficate p phys	edicai	`	d										
hat the death certificated by the attending place of the detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				2002				23d. Date	e of deliv	/ery
deatl	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	t at time of d		Ectopic pre Other (spe					Mor	nth	Day Year
at the	Phy	9 Unknown			hi i		_			Lag. Billion			
w requires that been signed b should be deta	þ	Part II. Other significent conditions co	ontributing to deat	n but not resi	uiting in the ur	nderlying ca	use give	n in Part I.		1 Ye	/		the cause of death?
w requires to been signed should be	etec		-			_				24a. Was a			opsy findings avaitable
he lav	Completed									autops	ned?	prior to co death?	omptetion of cause of
lan: T rifficate stor, pa	Φ	25. Was case reterred to medicat						26. Place	of Death	(Check only on		☐ Yes	2 ₩6
Physician: rthis certifica	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗌 Inpa	atient 2 🗌	ER/Outpatien	t 3 DO	Otho				ence 6 Othe	er (Speci	fy)
ng Phy Mer this		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	1	c. Injury Work			8d. Describe ho	ow injury occurr	ed	
Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	One Place of	Jaium. At he		M		es 2□N		19f Location (C)	troot and Alumbu	or or Pur	To Courte Aliverta
or All after of Direction by	ertification;	4 Homicide determined	28e. Place of building,	etc. (Specify		eet, factory,	опісе		4	City or Town	n, State)	ar or Hur	ral Route Number,
To the Hosultai or Attending Physician: The law within 24 mours after death. To the Funded Director: After this certificate has completely filled in by the funderal director, page 2.	C	29a. Certifier 1 Dertifying Phy (Check only 2 Medicel Exam	iner: On the basis	s of examina	wtedge, death tion and/or inv	occurred a	t the time	e, date and inion, deat	l place, a	and due to the ca	ause(s) and ma ate and place, a	nner as s	stated. to the cause(s)
Fo the within 2 Fo the somplet	Medic	29b. Signature and title of certifier	and manner	ctator									
F 3 F 8		1		-2			1)4	149	73	4	foril o	76	2006.
(h	1	30. Name and address of person who o	ompleted cause of	of death (Item	1 23a) (Type,	Print)	V (11	-		0.7
10	1		AWHOVE	7 ,	325 H	JIPZC	AL	DRIL	/€,	GLENI	Burn.	TC I	2006. MD 21061.
S [.] Regis	tate trar	31. Date filed (Month, Day, Year) APR 2 6	. 137		-	Carle	,						

State of Maryland / Department of Health and Mental Hygierie Certificate of Death

2. Date of Death

Month

APRIL

Dav

17,

0	6		3	40000	1	5
-	1	1	9			-

Year

2006

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

<u>21231</u>

Approximate Interval Between Onset and Death

4c. County of Death

3. Time of Death

2:30

10d. Inside City Limits 1 XYes 2 No

Birthplace (State or Foreign Country)

7	Examir	er	4a. Facility Name (If not institution, give	street and number)			4b. City, T	own, or l	Location o	f Death		40	County	of Deat	h
		45	ST. AGNES HOSP	ITAL			BAI	TIM	ORE						
	Funeral Director		215-14-5551	X 7. Age XIM 2□F	(In yrs. la	st birthday) Yrs.	If Under	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of (Month, 07/0	Birth <i>Day, Year)</i> 1/19	23	9. Birt Co M	hplace (State ountry)
	the Maryland 28a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD BALTIM	ORE		Town or Lo									10d. Inside C
	th with the 23a or 28a aut be not	Funeral Director	10e. Street and Number 101 N. BEECHWO				10f. Zip (Code 1228					tizen of W	/hat Co	untry?
920	urs after dea el', or Iteme	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:				ent of His fy Cuban			cify Yes or Rican, etc.)	No-		k, Whit	
Maryland 21215-0036	thin 72 ho e. an "natur Mulical	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed) College (1-4or 5-	+)	16a. Deced (Give life. L	ent's Usual kind of work O NOT use	k done du	tion uring most	of worki	ng	16b. K	(ind of Bu	siness/	Industry
1d 21	s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than other treumatic svent, the Me	Ве Соп	12th 17. Father's Name (First, Middle, Last)			PRES	SSMAN		18. Mothe	r's Name	(First, Midd		EWSP		ER
ylaı	should b nd Mente i marked umatic s	To E	un							THER					
	1 and 2 sh Health and Iem 27 is m		19a. Informant's Name/Relationship (T) LINDA MORROW/D	121							I Route Nur ALTIN				(ip Code) 21231
Baltimore,	82= 5		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		ce	ace of Dispos metery, crem	atory or oth	her place	1		7/200				Town, State
Balt	permit. Pa Department Importanti eny injury		21. Signature of Funeral Services Licens	land		22	Name and	d Address	of Facilit	y WE		CHAV	/IS,	JF	R. FH MD 2
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line	θ.	Do not ente	er the mode	of dying	, such as	cardiac c	r respiratory	arrest,			Approximation interval Bet Onset and
	/Medical Examiner		resulting in death)	Due to (or as a		ence of):									
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	conseque	ence of):									
68760,	srtificate be executed ing physician and e as the burial-transit	ledicai Ex	resulting in death) Last	Due to (or as a	consequ	ence of):									
-	5 0	ž	IF FEMALE:	A 10 - 11 - 12 - 13 - 1											

1. Decedent's Name (First, Middle, Last)

FREDERICK WILLIAM WIEGAND

Physician

/Medical

To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.

within 24 hours after death.

cort he Funeral Director: After this certificate has been signed by the attendint completely filled in by the tuneral director, page 2 should be detached for use

by Physician/N

Completed

Be

၉

Certification:

Medical

29a. Certifier

Division of Vital Records, P.O. Box

	2 Fetat death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			ate of delivery onth Day	Year
Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use con	tribute to the car	use of death?
Parkinson's Disease			1 ☐ Yes	2 🗆 No	3 Probably	4 Winknown

Atherosclerote Cardiovascular Disease

26. Place of Death (Check only one)

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

1 Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 | Homicide

28b. Time of Injury 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24a. Was an autopsy performed 1 ☐ Yes

29b. Signature and title of certifier

29c. License number 170058676

29d. Date signed (Month, Day, Year) April 25, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25 Main street, suite 200, Restriction, Babitt 31. Date filed (Month, Day, Year)

State Registrar

APR 2 6 2006



			1 - For State Registrar	State of M	laryland		artment rtificate			and M	-	giene Reg. No. 0 0 6	terinament of the second	3 46
	Physici /Medic		Decedent's Name (First, Middle, Edward Willis		te						2. Date of Dea Month		'ear	3. Time of Death 2 2/7 PM
	Examir		4a. Facility Name (If not institution, g Shady Grove Adv						Location o			4c. County of	Death Ltgon	nery
	Funeral Director			.Sex 7.Aq 1ÅM 2□F	ge (In yrs. Ias 81	t birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Aug • I	7, 1924	Birthpla Count Vil	ace (State or Foreign ry) rginia
	e Maryland ta-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	mery	10c. City, 1	fown or Lo							10	od. Inside City Limits 1 X Yes 2 □ No
	th with th	al Dire	10e. Street and Number 502 Fletcher Pla	ice			10f. Zip (ode 2085	1			10g. Citizen of Wh United		•
980	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28s-f show ta Medical Examilian mast te medited at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ▼ Yes 2 ☐ If Yes, Give Year or Dates:	?		Was Decede If Yes, specif 1 Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White, e	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar I Heelth and Mental Hygiene. Item 27 Ie marked other then "natural", or items 23s or 28s-f show other traumatic event, its Medical Exactinar mast be retilified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			16a. Dece (Give life.	dent's Usual kind of work DO NOT use Paint	done di retired)	tion u <i>ring</i> most	of worki	ng	16b. Kind of Busin		Dealershi _l
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event, the Mi	To Be (17. Father's Name (First, Middle, La Joseph W. White	st)					18. Mothe Alic			Maiden Sumame)		
	and 2 sho leelth and m 27 le m		19a. Informant's Name/Relationship Joseph Keith Wh			502	Fleto	her		e, R	lockvill	r, City or Town, St .e, Maryl	and	20851
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 🖁 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	Na Na	etery crar ArI tiona	natory or oth ing tor il Cem	eter		May 2	006	20c. Location - Ci	n, V	irginia
Bal	permit. Depertricity in the control of the control		21. Signature of Funeral Service Lic	W	M014	30	U West	Mont	gomery	Ave	nue, Rock	Rockville, wille, Mar	yland	1 20850
	Physician /Medical Examiner		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	o the death, ine.	au	er the mode				r respiratory and			Approximate Interval Between Onset and Death
8760,	ate be executed thysicien end the buriel-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	с.	a consequent									
P.O. Box 68	ne death certific the ettending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐Fetal de	ath 3	Ectopic pre Other (spec					23d. Date of Month		y Day Year
	v requires that the bear signed by should be detact	þ	Part II. Other significant conditions	contributing to death t	out not resultin	ng in the u	nderlying cau	ise giver	n in Part I.		23e. Did to	bacco use contribu		cause of death? bly 4 ☐Unknown
Vital Records,	i cian : The law certificete has b rector, page 2 sl	e Completed	25. Was case referred to me	erfeur	ell				26 Place	of Death	24a. Was a autop perfor 1 Yes	sy prio med? dea 2 No 1	r to com th?	sy findings available pletion of cause of
of V	Physician: this certific al director,	ToB	examiner? 1 Yes 2 No	Hospital: 1 Ninpati		/Outpatien		Other	4 □ Nur			ence 6 Other	(Specify)	
Division o	after and	Certification;	27. Manner of Peath 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	ha		b. Time of Injury	М		at ? es 2 □ N			ow injury occurred		
Div	pital or Al ours after of eral Directilled in by		4 Homicide determine	ed 28e. Place of In building, e	tc. (Specify)					2	City or Tow			
	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	(Check only one) 29b. Signature And title of certifier	Physician: To the best aminer: On the basis of and manner st	of examination	and/or inv	restigation, in	the time n my opi License	nion, deat	d place, a h occurre	ed at the time, o	ause(s) and mannelate and place, and	due to t	he cause(s)
	/ X \		30. Name and address of person wh	allin	alte	MI				26	2 j		21,2	2006
	β ¹ Sta	ite	31. Date filed (Month, Day, Year)	endhin	rar's Signature	240	1 Re	Jean	rch	BL	VD Sul	te 330 K	2040	ulle MD
	Registr		APR 2 6	2006	you D	B	selv							

			For State Registrar		State of M	arylan		artmen tificate					Reg. No.	006	and many water with	3 4	-
	Physicia	an	Decedent's Name (2. Date of De Month	Day	Yea	ar	3. Time of De	
	/Medic	al	Vernon 4a. Facility Name (If no	Francis			Jr.	45 City	Tour or	Lacation	4 Dooth	AFR		1 , 200 County of D		10:50	B M
	Examin	er	Saint J	oseph M	edical	Cent		If Under		Location o	W501			Ba:	lti	more	
	Funeral Director		5. Social Security Num 216-54-5	1/57	M 2□F 7. A9	54	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Oct11	y, Year)			ce (State or Fe y) land	oreign
	ס		Usual Residence of D	ecedent							'	OCCII	, 1))	1 1110			
	arylar ehow	_	Md.	ob.County Baltim	oro		y, Town or Lo ockeys		١٥						100	d. Inside City L 1 ☐ Yes 2	
	he M	ecto	10e. Street and Numb		1016	00		10f. Zip		_			10- 00	zen of What	C		2110
	with With I be or	i	10202 Da	-	Drivo				L030					USA	Counti	y t	
	death	Funeral Director	11. Marital Status		2. Was Decedent	Ever in U.	S. 13. V				gin? (Spe	cify Yes or No Rican, etc.)		14. Race - A			
336	s 1 and 2 should be filed within 72 hours atter death with the Maryland I Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23s or 28s-f ehow other traumatic event, the Madical Examiner must be notified at	þ	1 Never Married		Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	∳ \o		r Yes, spec		n, мөхісап <i>Specify:</i>	, Pueno r	tican, etc.)		Black, W Specify:		ite	
Maryland 21215-0036	72 hou	Completed	(Specify	5. Decedent's Educ only highest grade	cation		16a. Deced	lent's Usua	Il Occupa	ition	of working	10	16b. Ki	nd of Busine	ss/Indu	stry	
2	within 7 ene. then "r he Med	npie	Elementary/Second		College (1-4or	5+)				luring most)		<i>'</i> 9					
F F	e filed w Il Hygier other tl		12th 17. Father's Name (Fit	ret Middle (ast)			Cust	omer	: Se	TVic		(First, Middle			Te	chnolo	ogie
and	d be f antat h ked of	o Be	Vernon		s Wheel	er.	Sr.					Siebel		Jamanio,			į
3	2 should be in and Mental I ie marked or aumatic eve	T _O	19a. Informant's Nam			,		g Address	(Street a			Route Numb		r Town, State	e, Zip C	ode)	
ž	and 2 gaith a m 27 io		Colleen	Wheeler	/wife		1020)2 Da	aven	try	Driv	ve Coo	ckey	svill	Le,I	Md2103	30
ore	es 1 and of Health if item 27 ir other t		20a. Method of Dispos	sition Cremation 3 □Re	emoval from State	20b. P	lace of Dispo emetery, cren	sition (Nan natory or o	ne of ther place	9)	Da	ate	20c. Lo	cation - City	or Tow	n, State	
Ë	Pag ment tent: I		4 □ Donation 5	Other (Specify)		Bay						-06					
Baltimore,	permit. Pages 1 Department of F Importent: if its any injury or ot		21. Signature of Fune	ral Service License	land	7						zorows Balt				Home, 21222	, PA
			23a. Part1. Enter the shock, or heart f	disease, or complic ailure. List only on	cations that cause e cause on each I	d the death ine.	n. Do not ente	er the mod	e of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate nterval Betwee Onset and Dea	
ı	Physician		Immediate Cause (Fir disease or condition resulting in death)	nala	ANOXIO			OPA"	THY	SECC	INDAI	RY_TO				31100t di la 200	
١	/Medical Examiner		, and a second	- 1	Due to (or as		uence of): ARRES	ST.									
	1 7 9	-er	Sequentially list condificant, leading to immicause. Enter Underly Cause (Disease or inj	itions, b ediate	Due to (or as								_		+	_	
1	cuted nd ransit	amir	that initiated events	C C	CORONA	ARY A	ARTER	V DIS	SEAS	ŝE							
õ	e exe dan ar urial-t	icai Examiner	resulting in death) Las	st	Due to (or as	a consequ	uence of):								10		
8760,	death certiticate be executed e attending physician and id for use as the burial-transit			d											-		
Box 6	eath certitica attending ph I for use as th	/Me	IF FEMALE: 23b. Was decedent p	23	3c. If yes, outcome	of pregna	ncy							23d. Date of	deliver	,	
.O.	e death the atter	Physician/Med	in the past 12 mg 1 Yes 2 N 9 Unknown	onths?	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			Ectopic pro Other (sp						Month		ay Yea	r
<u> </u>	that the de ned by the s		Part II. Other significa	ant conditions con	tributing to death t	out not resi	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did 1	obacco u	se contribute	to the	cause of deat	th?
Records,	law requires that the as been signed by th 2 should be detache	ed by										1 🗆	Yes 2[□No 3□	Probat	oly 4 Nunki	nown.
900	e law re has bee je 2 sho	Completed										24a. Was		24b. Were	autops	y findings ava	ulable
Ě	The ate h page	Com										perfo 1 ☐ Yes	ormed? 2 No	death 1 □ Y	1?	No	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred examiner?	-	ocnital:				Otho		of Death	(Check only	one)				
of	Phys this aldii	 10	1 Yes 2 No	, "	ospital: 1 M Inpati 28a. Date of Inji		ER/Outpatien 28b. Time of			4 140		ne 5 Resi			pecify)		
o	Attending r death. actor: Atter by the funer	tion		5 Pending investigation	(Month, Da	ay Year)	Injury	м	8c. Injury Work 1 □ \	:? ∕es 2 ∐ h		.ou. Dosonio	now injur	y cocarrou			
Division	Atten or dea octor by the	Certification:	_	6 Could not be determined	28e. Place of In	jury - At ho	ome, farm, str	eet, factory	, office		2	8f. Location (Rural I	Route Number	;
	ital or irs afte rei Dir led in				Dunding, 6	to. (Specify											
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai	29a. Certifier ff (Check only 24 one)	⊠ Cartifying Phys ☐ Madical Examin	ician: To the best er: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurred restigation,	at the tim , in my op	e, date and pinion, deat	d place, a th occurre	nd due to the ed at the time,	cause(s) date and	and manner place, and c	as stat due to t	ed. he cause(s)	
	To the I within 2 To the I complet	Σ	29b. Signature and titl		mea	F. 8	N.D	290	. License	number				e signed (Mo		-	,
	\wedge		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Indn 1					0 41	410			HYR	12 21	- 1	200	p .
	12		30. Name and address		mpleted cause of		ne e en en		par ghan am	, fram	to, g g props assert	L J Jon Man	/1 /**	1975 370 1 7	er, just, a		
	Sta	te	JOGINDE F 31. Date filed (Month,		82. Regist		ture		DRIV	/E TC	JWSO	N_MAR	YLAN	D EIE	<u> 204</u>		
	Registr		31. Date filed (Month, APR)	2 6 2006	Asse	A	Macro	E									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ANDERSON JR. **Physician** JOHN FRANCES 9:00P M APRIL 8 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FORESTVILLE FORESTVILLE HEALTH & REHABILITATION PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 1 M 2 □ F Yrs. 18 577-52-9621 FEB. 1938 WASHINGTON, DC Director 68 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be nutified at 1X Yes 2 □ No MD PRINCE GEORGE'S CAPITOL HEIGHTS Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6810 SEAT PLEASAN T DRIVE # 102 20743 deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1⊠Yes 2□No Airforce If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: AFRICAN AMERICAN ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE WAREHOUSE SUPERVISOR 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe any injury or other treumatic event, sing. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) U/K JOHN FRANCIS ANDERSON SR. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6810 SEAT PLEASANTER. # 102 CAPITOL HEIGHTS, MD20743 PATRICK MAYE/STEP SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 4/13/2006 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATOCELLULAR CARCINOMA Pnysician /Medical Due to (or as a consequence of) Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2X No 1 Tes 1 Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funerel D 29a. Certifier 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0026024 10, 2006 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 LESTER MILES M.D. 6490 LANDOVER ROAD SUITE F LANDOVER, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 2 2006 Registrar

Amend #30 per Phy. 4-11-06 A.A.Co. Health Dept PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day April 6, 2006 **Physician** Year Francis Joseph Aluisi 2:14 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sunrise Assisted Living Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 5-16-1921 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F 84 Vrs Washington, Director 579-18-0621 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or itama 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1069 Foxcroft Run 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mertial Hygiene.
ant: if item 27 ie marked other than "naturel; or ital
ury or other traumatic event, its Medical Examinat 1 Never Married 2 Married If Yes, Give Year or Dates: 1942–69 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Civil Engineer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sabatino Aluisi Vincenza Capannelli 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is eny injury or other trac 1069 Foxcroft Run, Annapolis, MD 21401 James V. Aluisi/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 4-11-06 Suitland, Maryland 21. Signature of Mingral Seplice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy į in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 Tyes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes É No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Other (Specify) P No Hospital: Other: # Nursing Home 5 Residence 1 Inpatient 2 1 Yes 2 ER/Outpatient 3 DOA Director: After this of in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral Dir Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29b. Signature and title of certil 29c. License number 29d. Date signed (Month, Day, Year) Dr. Aditya Choora 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

1 1 2006

13150 State of Maryland / Department of Health and Mental Hygiene UU 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 April 9, **Physician** Abbott 5:40P M Viola Anna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0CT. 9, 1914 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕏 F 91 Pennsylvania Yrs. 197-03-8275 Director Usual Residence of Decedent with the Maryland 10c. City Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.
ant: if Item 27 is marked other then "natural", or Itema 23a or 28a-f shov rry or other traumatic event, the Madical Examinar must be nutited at 1 √ Yes 2 No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #103 20876 United States of America 12012 Amber Ridge Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mettie Rickrode Robert Hetrick P and of Health and Artant: If item 27 is my injury or other tr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12012 Amber Ridge Circle #103, Germantown, MD 20875 Jo Olivia Abbott - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: if any Injury or once. 04/14/06 Ft. Lincoln Crematory Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service tricensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Arrythmia /Medical Due to (or as a consequence of): Examiner Ventricular Tachycardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 wronths? 1 ☐ Yes 2 ☐ No Month Day Year 4□ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No rector, page 2 s ormed? 2 🖾 No 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient ဥ 1 Yes 2 XNo 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation il Diractor: / 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-10-2000 H0051280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive #201, Rockville, MD 20850 Anushiravan Dadgar

DHMH 17 Rev 1/2001

Registrar

31. Date liled (Month, Day, Year)

APR 12 2008

32. Pagistrar's Signature

							artment of H		-		•		
		1	For State Registrar	Olale C	i waryta		rtificate of I		vicinairiy	Reg. No		13	151
Dhu			1. Decedent's Name (First, Middle, I		0	24-	-		2. Date of De	aath		3. Tim	ne of Death
	sicia ledica	1	BLONDIE			MIE			APR) Da			/\ M
Exa	amine		A D D C A Support of the A D D C A Support of the A D D D C A Support of the A D D D D D D D D D D D D D D D D D D					Location of Death	1		. County of Dea		
Fune	aral		Anne Arundel 1 5. Social Security Number 6.	Sex A		er s. last birthday)		If Under 24 Hrs.	8. Date of Bir	Ar	ne Ar		ate or Foreign
Direc			263-72-1146	1□M 200 F		65 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da June	3, 1	940 F	ountry) L	
and	4	-	Usuat Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d Insid	le City Limits
Maryi -1 eho	000	5	MD. PG		Ur	per M	ar1boro						Yes 2 □ No
th the		liec I	10e. Street and Number			par in	10f. Zip Code			10g. Cit	tizen of What C	ountry?	
ath wi	MBLS	runeral Director	120 Stan Fey				207				ited S	tates	5
ter de		nue	 Marital Status Never Married 2 Married 	Armed Fo	edent Ever in lorces? 2 (31No	U.S. 13.	Was Decedent of Hit Yes, specify Cuba	ispanic Origin? (Si in, Mexican, Puert	pecify Yes or No o Rican, etc.)	>-	14. Race - Am Black, Whi		1,
.UU.3D hours after death with the Maryland tural: or Items 23s or 28s-f show		2	3 XWidowed 4 Divorced	If Yes, Gi Year or D	Ve		1 ☐ Yes 2 🗵 No	Specify:		i	Specify:	lack	
	1	Completed	15. Decedent's (Specify only highest of	Education Trade completed		(Give	dent's Usuaf Occupa	during most of wor	kına	16b. K	ind of Business		
within 72 ene.	a Mis	Ē	Elementary/Secondary (0-12)	College (life.	DO NOT use retired)	3	D			
W 5. 4	The second	3	12 17. Father's Name (First, Middle, La	st)		Раре	er Bag M	18. Mother's Nan	ne (First, Middle		ivate		
/ Fand		0 De	Unknown					Unknow	vn				
Mary d 2 shorth and h	sums		19a. Informant's Name/Relationship				ng Address (Street a			er, City o	or Town, State,	Zip Code)	
C = 14 P		-	Darlene Benson	n/daugh		Jugi	Oak Fo	rest Co	88E46				
ages 1 nt of F	5	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		State	cemetery, crer	sition (Name of natory or other plac		Date		ocation - City or		
attimore, mit. Pages 1 a partment of Hea portant: If Item	inforce in	-	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service-Lic		, Re		tion Ce		20/06 Hodges		inton		
Departition	POCE		Januce Ea	wand	2		910 Si1						
e#			23a. Part1. Enter the disease, or co shock, or heart faifure. List on	mplications that of	caused the dea	ath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	- ozum	Approxi	
Physici			fmmediate Cause (Finat disease or condition	, u	itra (Deroh	ul E	leed					D Death
/Medic			resulting in death)	Due to	for as a conse	quence of):	Palin					110	01
8.		5	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a conse	quence of):						J	ans
V petro	He He	Cyanille	cause. Enter Underlying Cause (Disease or injury that initiated events		,								
be executed sicien and			resulting in death) Last	Due to	(or as a conse	quence of);							
	2	2		d									
X cert	מומרוומר וכן המפ מה	DIA C	IF FEMALE:	23c. If yes, ou	tcome of pregr	nancy					23d. Date of de	France :	
death cer death cer death cer		2	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live t 4□Pregr	ointh 2 Fet nant at time of	aldeath 3□	Ectopic pregnancy Other (specify)				Month	Day	Year
D at the designation of the desi	Tacilla	2	9 □ Unknown	9□ Unkn									
law requires that the de es been signed by the a		5	Part fl. Other significant conditions	contributing to d	eath but not re	sufting in the u	nderlying cause give	on in Part I.			use contribute to		
ecords law requires es been sign	Dipole 2 affect		Dich		Land	100	100	4201	10,		/		Unknown
hes hes	2 1	<u>-</u>	Danver	0.41	* * * * * * * * * * * * * * * * * * * *	3 per	di	ala . º	24a. Was autor perfo		24b. Were as prior to death?	utopsy findir completion	igs available of cause of
VITAL P lician: Th certificate		b :	25. Was case referred to medical	Sam	alen	7	a	26. Place of Dea	1 ☐ Yes	≥□ No		2 No	
_ × × · × ·	De la	o	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	\C	ome 5 Resi		6 □Other (Spe	cify)	
ing Phy Miter thi	0		27. Manner of Death 1 ☑Naturaf 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. fnjury Work	:?	28d. Describe	how infu	y occurred		
JIVISION or Attending after death. Director: After		2	2 Accident investigati 3 Suicide 6 Could not	be 200 Bloom	ad laine. As t			res 2 □No	20f Leasting (Ctaratar	od Alicentra O		
after Direct			4 Homicide determine	d 286. Place build	ing, etc. (Spec	nome, tarm, str lify)	eet, factory, office		28f. Location (: City or To	wn, State))	urai Houle r	lumber,
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Fundral Director: After th complished filed in by the fundral		2	29a. Certifier (Check only 2 Medical Ex	hysician: To the	best of my kn	owledge, death	occurred at the tim	e, date and place,	, and due to the	cause(s)	and manner a	stated.	
ths Hi nin 24 the Fu	alaidi alaidi	200	0.107	and man	ner stated.	ation and/or inv	estigation, in my op		rred at the time,				
o	3		29b. Signature and file of certifier	Total A	Zus		29c. License	number	120	29d. Dat	te signed (Mon	h, Dey, Yea	1)
/	(1	30. Name and address of person wh	o complete day	se of death /#=	m 23a) /Tun-	Print) =) VI	128	Y	JVV 1	6 6	1006
5			MICHAEL J	LAVE	J A	M 44	5 Def	ENSETH	16 HW A	Ay H	NNAPOL	SMD	4401
NO. NO.	State		31. Date filed (Month, Day, Year)		Registrar's Sign		W-7		[#] *	1 4			
Reç	gistra		APR 2 6 20	006	CARA B	S GOOD	les .						

			_ For	Type or Prin State of Ma								_	e.		
			1 - State Registrar			Cer	tifica	te of	Death		Reg. N	0.	5	131	52
	Physicia		Decedent's Name (First, Middle, La Darlene	st)	H	Bostic				2. Date of D Month April	D	ay 200	ear 6	3. Time of 9:25	
)	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. Cit	y, Town, o	r Location of Deat			c. County of		,,	P
			Hospice House					Linth	nicum			Anne	Aru	ndel	
	Funeral Director		213-04-2413	CIN SERVE	je (In yrs. la 50	ast birthday) Yrs.	If Und Month	er 1 Year s Days	If Under 24 Hrs Hours Min.	8. Date of B (Month, D Aug.	av. Yea	r)	Count	ace (State o ry) hDako	
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside C	·.
	Ba-f	Director	MD Anne Ar	undel	L	Severn									XXNo
	with the		10e. Street and Number				10f. 2	ip Code			10g. C	itizen of Wha		ry?	
	eeth ee 23.	eral	1901 Cuire Drive	12. Was Decedent	Ever in 113	12 1	Nac Dec	211		pecify Vee or N	0-	14. Race -		n Indian	
036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f ehow aumatic event, the Madical Examinar must be inclifted at	by Funeral	1 X Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:				2X No	tispanic Origin? (S an, Mexican, Puer Specify:	o Rican, etc.)	0-		White, e	tc.	
21215-0036	in 72 ho n "natura dadical I	Completed	15. Decedent's E (Specify only highest gra	ide completed)		16a. Deced (Give life. L	kind of v		during most of wo	rking	16b.	Kind of Busin	ness/ind	ustry	
212	yiene.	E	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Admi	nist	rato	r			Market	ing		
פ	be filed ital Hygi of other event, I	a	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	, Maide	n Sumame)			
Maryland	uld bu Menta Menta Irked Itlc e	To B	Harry O. Bostic						Gladys	E. Str	oman				
ar)	ss 1 and 2 should b of Heelth and Ment litem 27 is marked r other traumatic e		19a. Informant's Name/Relationship (and Number or Ri						
	end eelth m 27		Jacqueline B. Ci	comer (Sist					k Road,						
ore	or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □	Removal from State	206. PI	ace of Dispo metery, cren	sition (N natory o	ame of rother plac	1	Date		Location - Ci	ty or To	vn, State	
altimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		4 □ Donation 5 □ Other (Special		Mea	dowrid	_			12-2006	Ва	ltimor	e, 1	MD	
Ba	Depar mpor mpor iny In		21. Signature of Funeral Service	900		22			ss of Facility Funeral	Home.	P.A	_			
	90549		7 70 0	6	d sh - daash	- T	12	Ridge	Funeral	ie. Anna	pol:	is, MD	214	01	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each li	the death	. Do not ent	er the m	ode or dyir	ng, such as cardia	or respiratory	arrest,			Approximat Interval Bet Onset and I	tween
· ·	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a///		Lash	1		ulon	Con	rce	\sim		29	len
	Examiner		1	Due to (or as	a consequ	ence of):								0	
		F.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence of):									
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·									1		
,	be executed sicien and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):									
	e be ey /sicien e buria			d											
89	tificate ig phys as the	led	12												
Rox	leath certificate i attending physi	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic	pregnancy	,			23d. Date of		-	
E	Physician: The law requires that the death certificate this certificate has been signed by the attending physral director, page 2 should be detached for use as the	by Physician/Medical	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at 9☐Unknown			Other (Month		Day '	Year
J.	thet the de led by the a detached t	Phy				441 1 - 44			. to more at	02- 04	120000				d= -4b 2
Vital Records,	ires the signed the det		Part II. Other significant conditions	contributing to death b	ut not resu	iung in ine ur	nderlying	cause giv	en in Part I.			use contribu		ibly 4 ⊟l	
9	w require been sig	Completed										1			
Sec.	has t	ď								24a. Wa auto	s an opsy ormed?	pric	re autop or to com oth?	sy findings ipletion of c	available ause of
a	ilcian: The l certificate ha rector, page									1 ☐ Yes	2 Z		Yes		
=======================================	slciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Oth	26. Place of De			۷	- 1 - 0	HOS	
ō	tending Physician: leath. tor: After this certific the funeral director.	7: To	1 ☐ Yes 2 Ø No 27. Manner of Death	28a. Date of Inju	ıry	28b. Time of		28c. Injur	er: 4 ☐ Nursing H	lome 5 ☐ Res 28d. Describe					DUGE
5	ding th. th. After funer	ţ	1⊿Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year)	Injury	М	Wor	k? Yes 2∐No			,		•	30
Division of	l or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be determined	286. Place of inj			eet, facto	ory, office		28f. Location			or Rural	Route Num	nber,
ā	ospital or A hours after unerel Dire ly filled in by	Sert	4 Hornicide	building, et	c. (Specity	,				City or To	own, Sta	ie)			
	I 4 II D	edical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best miner: On the basis o and manner sta	f examinat	vledge, death ion and/or inv	occurre	ed at the tir on, in my o	ne, date and place pinion, death occu	, and due to the irred at the time	cause(s) and mann nd place, and	er as sta d due to	ited. the cause(s	5)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	1~1	A		2	9c. Licens	e number		29d. D	ate signed (/	Month, E	ay, Year)	
	0		Michael	1 Offer	Tau	1		D	2143	8	1	Ami	1 0	7,20	106
•			30. Name and address of person And MICHARD LAPER	completed cause of d	death (Item	23a) (Type,	Print)	LIGH	WAY A	IN APOLIS	-/ N	n 2	1401	1	
	Sta Registr		31. Date filed (Month, Day, Year)		rar's Signat			9	117		- 11	1)			

			1 - For State Ragistrar	State of M	1 arylan		artment rtificate			ind Me		iene	16	13	53
	Physici	an	1. Decedent's Name (First, Middle,	,							Date of Dea Month	Day	Year	3. Time of	_
	/Medic	al	David Gordon		-1		45 035 3		Location of		April	9 20 4c. County	006	2:50	Ам
	Examin	er	4a. Facility Name (If not institution, Genesis Elderca)			ter			polis			Anne			
	Funeral		5. Social Security Number 146–14–5079	6. Sex 7. A	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)	Cou	place (State o	
	Director		Usual Residence of Decedent								June 19	, 1923	INE	w York	
	show		10a. State 10b. County)	10c. Cit	ty, Town or Lo		74	_					10d. Inside C	•
	Ne Ma	ecto		Arundel			Anna		S ———			0			2 🗆 No
	with t	٦	10e. Street and Number 758 D Fairview A	Avenue			10f. Zip		21403			0g. Citizen of U	S.A.	,	
	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel", or items 23a or 28a-f show d other then "naturel", or items 23a or 28a-f show event, the Medical Exember must be notified at	Funeral Director	11. Marital Status	12. Was Deceder Armed Forces			Was Deced	ent of Hi	spanic Orig	gin? (Spec	cify Yes or No-		ce - Ameri ck, White	ican Indian,	
ရ	or Ite	by Fu	1 Never Married 2 Marrie] No		1 ☐ Yes 2		Specify:	,	noun, sto.	Specil		ite	
212-0030	ture!	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent*		: ****		dent's Usua	I Occupa	ation			16b. Kind of B	usiness/li	ndustry	
<u> </u>	hin 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-40	r 5+)	(Give	kind of wor DO NOT us	k done d e retired	luring most)	of workin	g			,	
N	filed wit Hygiene other the	Соп		5+	,	Co	mmand	ant				U.S. G		ment	
⊑	_ C =	To Be	17. Father's Name (First, Middle, L Joseph Boak, J								(First, Middle,Richa		πe)		
lar)	ss 1 and 2 should of Health and Men (Item 27 ie marke r other traumatic		19a. Informant's Name/Relationsh								Route Number	-			0.2
	1 and Health sm 27 ther ti		Mary F. Boak/W	тте	20b. F	Place of Dispo	sition (Nam	ne of			Annapol	20c. Location			.03
ב ב			1 ☐ Burial 2℃ Cremation 4 ☐ Donation 5 ☐ Other (Sp		e	cemetery, crei	matory or of	ther plac	-	4/11	/2006				nd
saltimore,	in production in		21. Signature of Fyneral Service	4	Da	22	2. Name and	d Addres	s of Facility	John	M. Tay	lor Fur	neral	Home	
ñ	Ded imp		Michel /	-							er St.		olis,	MD 21	401
	Physician /Medical	5781	23a. Pant 1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	line.	SI	. 4	_			respiratory arr		^	Approximal Interval Bel Onset and	ween
	Examiner	į l	Conservation of the condition of	4		(201100 0.).					22	100			
	pe tis	lner	Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	luence of):									
	cate be executed bhysicien and the burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or a	is a conseq	juence of):						 			
8/PU	ysicier ysicier	dical		d.											
	ertifica ing ph e as th	Med	IF FEMALE:												
C. BOX	at the death certifics by the attending ph stached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3	Ectopic pre Other (spe						ite of deliv		Year
л, Г.	as the gned	ρ	Part II. Other significant condition	ns contributing to death	but not res	sulting in the u	inderlying ca	ause give	en in Part I.		23e. Did to	bacco use con	tribute to		death? Unknown
S S	> 0 70	letec				-					24a. Was a		Were aut	onsy findings	available
Vital Record	e la has	Completed									autops perfor	med? 2 No	prior to codeath?	opsy findings ompletion of c	ause of
II a	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?							of Death	(Check only or	<u> </u>			
0	Physic this co	္	1 ☐ Yes 2 No 27. Manper of Death	Hospital: 1 ☐ Inpa 28a. Date of In		ER/Outpatier			4 Nu		ne 5 Resid			ify)	
5	ding In.	tlon	1 Matural 5 Pending 2 Accident investig	(Month, E	Day Year)	Injury	M 2	8c. Injury Work	vat k? Yes 2 □ N		ou. Describe in	ow injury occu	160		
Division	of or Attending Physicien: atter death. I Director: After this certific d in by the funeral director,	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of I	njury - At h etc. (Speci	ome, farm, sti fy)	reet, factory	, office		2	8f. Location (S City or Town		ber or Rui	ral Route Nun	nber,
	Hospite 4 hours Funers ely fille	edical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the be- xaminer: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred avestigation,	at the tim	ne, date and pinion, deat	d place, a	nd due to the cod at the time, o	ause(s) and m late and place,	anner as and due	stated. to the cause(s	s)
	To the Horwithin 24 h To the Fur	Mec	29b. Signature and title of certifier	5.1			29c	License	number	0		9d. Date signe			
			> 7. Tel	louis	10			UK	183	8		4/10	0/2	006	
			30. Name and address of person v	who completed cause of		m 23a) (Type,	Print)	0	Re	stac	ate Ri	1. Au	Ищо	olès M	1d.
	Sta	ite	31. Date filed (Month, Day, Year)	32 Regis	strar's Sign		,		100	-0-	24- 10		0		
	Registr	rar	APR 11	2006		k do	ack s								

			State of Maryland / Department of Health and 1- For State Registrar Certificate of Death		giene 006	13154
	Physicia	an	1. Decedent's Name (First, Middle, Last) Kathryn W. Beck	2. Date of Dea Month April	9, Day 2006 Year	3. Time of Death 9:15 p M
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Wilson Health Care at Asbury Village Gaithersburg 5. Social Security Number 6. Sex 7. And (In vrs. last birthday) If Under 1 Year If Under 24 H			ntgomery
	Funeral Director		225-18-9901 1 M 2 F 88 Yrs. Months Days Hours M	lin. 8. Date of Birth (Month, Day) June 9,	1917 Vi	thplace (State or Foreign ountry) rginia
	e Maryland 3a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Gaithersburg			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	3e or 26	i Director	10e. Street and Number 19317 Poinsetta Court 20879		10g. Citizen of What C USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show month in the marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire M. Jical Estrains must be notified alonge.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, specify Cuban, Mexican, Pu 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 14. Was Decedent Ever in U.S. Amed Forces? 15. Was Decedent of Hispanic Origin? 16. Yes, specify Cuban, Mexican, Pu 17. Yes, Sive Year or Dates:	(Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi Specify:Whi	te, etc.
Maryland 21215-0036	d within 72 ho jiene. ir then "natur ir e Madicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of with a complete of the complete of t	working	16b. Kind of Business Own	I Home
land	uld be filed fental Hyg rked othe lic event,	To Be C		Name (First, Middle, a M. Heade		
Mary	nd 2 shoulth and N 27 is mai		19a. Informant's Name/Relationship (Type, Print) Edward G. Beck/ Son 19b. Mailing Address (Street and Number or 19317 Poinsetta Court			
Baltimore,	Pages 1 are ent of Heart if item y or other		20a. Method of Disposition 1	Date ril 13, 2006 E	20c. Location - City of	
Baltii	permit. F Departm Importar eny injur		21. Signature of Funeral Service Licensee #2 Name and Address of English in 500 University BI	ns Funeral	Home Inc	
8760,	Physician buyasicien and buyasicien and steep physicien and steep	dical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		051,	Approximate Interval Between Onset and Death
P.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	olivery Day Year
	es De	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Resultance of peccesses.	23e. Did to	obacco use contribute to	o the cause of death?
al Records,	The ate h	Completed	Explication Syperterision		rmed2 prior to death? 2 No 1 □ Ye	utopsy findings available completion of cause of
ion of Vital	Attending Physician: 7 death. • ctor: Atter this certifical by the funeral director, p	ertification; To Be	examiner? 1		lence 6 Other (Sp.	ecify)
Division	al or Attend s after death if Director:	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or F vn, State)	lural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funaral Directo completely filled in by ti	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death or and manner stated.			
	within To th	×	29b. Signature and title of certifier 29c. License number 29c. License number		29d. Date signed (Mor	
•	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ RUBSET B(RS(-(3)) (C)) 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	SELL A	VEXILE OF DEL	20877
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 2 2006 APR 1 2 2006	10000	7,000	/

06-02647 Kaafee Billah

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Rea. No Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day April 18, 2006 1919 hrs Medical Examiner Billah Kaafee 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 25 West Watkins Mill Road Suite F Gaitherburg Montgomery If Linder 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Bangladesh Months Days Hours Director 095-86-1817 39 10/5/1966 1 X M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits any 10b. County GA Stone Mountain Gwinnett 1 X Yes 2 No or 28a-f show s 23a or 28a-f show e notified at once. nours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5480 Village View Lane 30087 Bangladesh Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, þe Armed Forces? 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes Asian Yes, Give Year Yes 2 X No specify: Widowed Divorced ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than' MD 21215-0036 Economist 5+ .. Pages 1 and 2 should be filed within 'tment of Health and Mental Hygiene rant: If item 27 is marked other than Compl Biotechnology 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) M.Abul Kasem Bulbul E. Jannat M.A. Oasim Jannat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stone Mountain, GA 5480 Village View Lane, Snigdha Ali wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Itimore, crematory or other place) X Burial 2 Cremation 3 Removal from State 4/24/06 Bangladesh Family Cemetery Other Specify Donation 5 22. Name and Address of Facility Signature of Funeral Service Licensee Universal Mortuary Bal 06 Washington, Kennedy St., N.W. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Immediate Cause (Final disease Acute myocardial infarction due to xaminer or condition resulting in death) Due to (or as a consequence of) Coronary Artery Thrombosis due to Sequentially list conditions Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause Examiner Atherosclerotic cardiovascular disease (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X AMENDED item#5,17,18,23a-c,27,perFH,ME,g855,5/10/06. TT X UNPENDED nttending physician or use as the burial Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23d Date of delivery 23c. If yes, outcome of pregnancy Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Yes 2 Yes No 1 1 Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene After this 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No 5 Pending after death. the Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started within 2 To the F 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2006 Name and address of person who comple ed cause o veath (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (MATORIY, 2º1 State 2006 Registra

06-02542 Ellen D. Brooks Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of D	, ,	Reg. No.	2006 13150
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)			Date of Death Month Day April 14, 2006	Year 3 Time of Death 1030 hrs
par	E11en D. 4a. Facility Name (if not institution, give street and	Brooks T4b.	City, Town, or Location of Death		ounty of Death
	Laurel Regional Hospital		_aurel	1	nce George's
Funeral	5. Social Security Number 6. Sex			8. Date of Birth (MM/DD	(YYYY) 9. Birthplace (State or Foreign
Director	216-09-1852 1 M 2XF Usual Residence of Decedent		Months Days Hours Min.	Feb.20,19	
v any	10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
faryland 28a-f show Latonce. ector	MD Prince Georg				1 X Yes 2 No
the Maryland a or 28a-f sh tiffed at once Director	10e. Street and Number	1	Of. Zip Code		of What Country?
oith the Maryland r.23a or 28a-fshov notified at once. al Director	500 9th Street 11 Marital Status 12 Was D	ecedent Ever in U.S. 13. Was D	20707 Decedent of Hispanic Origin? (Spec		S.A. Race - American Indian, Black,
or death with		Forces? If Yes,	specify Cuban, Mexican, Puerto Ri	can, etc.)	White, etc.
safter d	3 X Widowed 4 Divorced If Yes, Give or Dates:		es 2 X No specify:	Sp	ecify Black
hours matur Exami	15. Decedent's Education (Specify only highest g	during most	Usual Occupation (Give kind of wor of working life. DO NOT use retired	3)	of Business/Industry
5-0036 ed within 72 hour tygene. tygene. the Medical Exar	Elementary/Secondary (0-12) College 9th	(1-4 or 5+) House	reener		hn Hopkins iversity
5-0036 ed within 7 tygiene other than the Medica	17. Father's Name (First, Middle, Last)	nousei		irst, Middle Maiden Su	
21(be fill be	George E. Matthew			L. Mitch	
should should md Me is ma aire ex	19a. Informant's Name/Relationship (Type, Print)		ddress (Street and Number or Rui		
e, MD 2 and 2 shou tealth and M tem 27 is n traumatic	Judith James - Niec 20a. Method of Disposition	20b. Place of Dispositio	th St Laurel,		20707 ation - City or Town, State
등 등 등 기	1 X Burial 2 Cremation 3 Remova		· · ·		
Baltimo Pag Department Important:	4 Donation 5 Other Specify 21 rig ature of Funeral Service Licensee	MD Nation	nal Park 4/2 ne and Address of Facility Snov	21/06 Lai	urel, MD
Balt permit Departi Import	(agest & X	1000 / 246	N. Washingto	on St Rocl	cville,MD20850
Physician	23a. Part I. Enter the disease, or complications that failure. List only one cause on each line	caused the death. Do not enter the	mode of dying, such as cardiac or re	espiratory arrest, shock,	or heart Approximate Interval Between Onset and
/Medical	Immediate Cause (Final disease a. Metas	tatic adenocarcinoma	of the colon with co	mplications	Death
	h	s a consequence of);			
ner		a consequence of);			
nsit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or a	s a consequence of):			
	dd.				
760, icate be executed. physician and the burial - transit	X UNPENDED AMENDE	item#23a,27,perME,	g856,6/30/06 TT		
F ica ica	IF FEMALE: 23c. If ye 23b. Was decedent pregnant in the	s, outcome of pregnancy	death 3 Ectopic pregnand		ate of delivery
Box 68's e death certifith the attending ed for use as a hysician,	past 12 months?	gnant at time of death	death 3Ectopic pregnand (Specify)	ey Mc	onth Day Year
), Box 68 the death certi by the attending triched for use as Physician		known			
ires that the de signed by the 1 be detached f	Part II. Other significant conditions contributing	to death but not resulting in the und	erlying cause given in Part I		contribute to the cause of death? o 3 Probably 4 Unknown
ds, F quires en sig uld be					24b Were autopsy findings available
Records, The law requires ficate has been sig page 2 should be Completed				autopsy performed?	prior to completion of cause of death?
tal Rec cian: The certificate ecctor, page Be Com	25 Wee cope referred to medical		Of Black of Back (Charles	1 Yes 2 No	1 Yes 2 No
Division of Vital Records, P. rat or Attending Physician: The law requires the rs after death at Director: After this certificate has been signed in by the timeral director, page 2 should be destrification: To Be Completed b	25 Was case referred to medical examiner? 1 ✓ Yes 2 No	Inpatient 2 V ER/Outpatient 3	26 Place of Death (Check on DOA Other Nursing I		6 Other
n of \\ ling Phy After th tuneral on: To	27. Manner of Death 28a. Da	te of Injury 28b. Time of Injur		3d. Describe how injury	
Division o spital or Attending nours after death neral Director: Aft filled in by the tune Certification:	1 X Natural 5 Pending 2 Accident Investigation	ini, Day, reary	1 Yes 2 No		
or At or At after d Direct I in by	3 Suicide 6 Could not be 28e. P	ace of Injuiy - At home, farm, street, f	factory, office building, etc.	Bf. Location (Street and or Town, State)	Number or Rural Route Number, City
Di hours a meral J y filled	4 Homeide determined (Speci				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician	one) 2 Medical Examiner: On the bas	est of my knowledge, death occurred sef examination and/or investigation			
We see see	29b Signature and little of certifier	r state	29c License number	29d Date	e signed (Month, Day, Year)
<u> </u>	XICAY	10	O.C.M.E.	April 1	5, 2006
	30. Name and address of person who completed c		Charak Dalkinson Arts 6 222		
State			Street, Baltimore, MD 2120)1 ————————————————————————————————————	
Registrar	31. Date filed (Month, Day, Year) 2006 32	Registrar's Signature			

g, Steven		cchd AE Si 1-For State Amend #1 Registrar	tate o	of Maryland M.E. 4/	/ Dena	tment o	of Healt	h and l		/giene	Reg. No.	0.0	6	1315
Physicia	n/	Decedent's Name (First, Midd	le,Last)							2. Date of D	eath	Year		of Death
dical Examir	er	Stephen 4a. Facility Name (if not institution 1830 Accokeek Rd.	on, give		Berg		4b. City, T		cation of Death	Month April 7,	4c. Cou			12
Funeral Director	_	5 Social Security Number 214-06-7979	6. Sex	7. Aç	ge (In yrs. Ia: 21	st birthday) Yi	Months	r 1 Year Days	If Under 24Hrs. Hours Min.		Birth (MM/DD/Y		Country)	State or Forei 71 and
۶.		Usual Residence of Decedent 10a. State 10b. County			100 City 7	Fa				,				
ow any		10a. State 10b. County MD Cha				rown or Loca aldor								side City Limit Yes 2 X N
Maryland r 28a-f show : ed at once.	Director	10e Street and Number	TIE	5	VV .	aruor	10f. Zip		0.0		10g. Citizen of		ountry?	
th with the Ma tems 23a or 28 st be notified	Funeral D	5135 A Shaw 11. Marital Status 1 X Never Married 2 N	re F	lace 12. Was Deceden Armed Forces					U∠ nic Origin? (Sp exican, Puerto l		No- 14 R	USA ace - Am /hite, etc	nerican India	an, Black,
s after dea ral", or ii	by Fur	3 Widowed 4 Div	vorced	1 X Yes 2 If Yes, Give Year or Dates:	No	-	Yes 2				Spec		√hite	<u>.</u>
hour "natu	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 1.2		ly highest grade coi College (1-4 or	+0	during		·	(Give kind of w	ork done	16b. Kind o	f Busines	ss/Industry	
5-0(lled wi Hygier I other		17. Father's Name (First, Middle	, Last)					18.1	Mother's Name	(First, Middl	e, Maiden Surna	ime)		
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene. 127 is marked other than umatic event, the Medical	To Be	Stephen Ala 19a. Informant's Name/Relations				19b. Mailir	ng Address	(Street ar	Christ nd Number or R	ine I	ee lumber, City or	Town, St	ate, Zip Coo	de)
e, land and Health item		Christine K 20a. Method of Disposition 1 Burial 2 X Crematio		_	tate Cr	ematory or c	itner place)				laldori 20c. Locati			
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:		Br	insfi 945 ₂₂	eld-l	Echo]	ls 4/1	2/06	Charl CRAL HO	Lott	е На	11,MD
Physician		David Echols (pe: 23a. Part I. Enter the disease, or failure. List only one cause	r compli	cations that caused	the death.	Do not enter	P.O. the mode o	BOX dying, suc	567, L.	A PLA	TA, MD arrest, shock, or	20 heart	646 Appro	iximate Interva
/Medical		Immediate Cause (Final disease or condition resulting in death)	e a. C	Contact Gunsh Due to (or as a cons			men						betwe	een Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	•	Oue to (or as a cons	equence of)	:								
ited d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	Oue to (or as a cons	sequence of)									
	edical	UNPENDED	X	AMENDED it	em#21,	perFH,G	855,5/1	/06 TI						
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate the Annus after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?		23c. If yes, outco 1 Live birth 4 Pregnant a	me of pregnations	2 F	etal death		Ectopic pregna	ncy	23d. Date Mont		ery Day	Year
Bo he dear y the ar hed fo	hys		known	9 Unknown	16 b				- 1- 0- 11	00 0				
b, P.O. Buires that the daring is signed by the	ρ	Part II. Other significant condit	ions	contributing to deal	in but not re	suiting in the	underlying	cause give	n in Part I.		tobacco use co res 2 V No		to the caus robably 4	
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed										topsy formed?	prior t	o completio	dings availablen of cause of
n of Vital Rec	Φ	25. Was case referred to medica	al				2	6.Place of	Death (Check o		3 2 110		163	2 140
Vit hysici rthis c	To B	examiner? 1 ✓ Yes 2 No	Ho	ospital: 1 Inpati	L	ER/Outpatier		OA Oth	ner ₄ Nursing	g Home 5	Residence	6 🗸 Ot	her: Scene	
ion of tending F eath tor: After the funer		27. Manner of Death 1 Natural 5 Pen 2 Accident Inve	iding estigatio	2Ba. Date of Injune (Month Day) Apr 7, 2006	ury Year)	28b. Time of 22:20	Injury 2	8c. Injury a		28d. Describ Subject sl	e how injury occ not self	curred		
Division pspiral or Attend hours after death eneral Director: y filled in by the f	ertification:	3 Suicide 6 Cou	ild not b ermined	28e. Place of Ir		me, farm, stre	eet, factory,	office build		or Town	(Street and Nu , State) okeek Rd.			
To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	(0.110.11)	aminer:	on the basis of exa	mination an									s)
To To	Me	29b Signature and title of cortific		and manner stated			29c.	License no	umber		29d Date s	igned (1	Month, Day,	Year)
15.1		30. Name and address of persor	le,	ompleted cause of	death /Itom 1	232)		O.C.M.I	E.		April 8, 2	2006		
With				ant Medical Ex			n Str ee t,	Baltimo	re, MD 2120	01				

10 His State

Registrar

Laron Locke MD. Assistant inequical 2.

31. Date filed (Month, Day, Year)

APR 1 2 2006

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

		-	For State Registrar	State of	of Maryl	•	irtment of F tificate of i		ınd M	lental Hy	gien Reg. No	HUD	Per residente	58
	o .		1. Decedent's Name (First, Middle, La	ist)						2. Date of D Month	aath Da	ay Yea	3. Time of	f Death
	Physicia /Medic		Λ	Marion E	31akel	ey				April			0035	5 М
	Examin		4a. Facility Name (If not institution, gire	e street and nu	ımber)		4b. City, Town, or	r Location of	f Death		40	c. County of De	ath	
			Calvert Manor Hea	lthcare	e Cent	er		sing S				Ce	cil	
	Funeral Director			Sex 118∑M 2 ☐ F	7. Age (In) 82	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, D July 2	av Year		irthplace <i>(State o</i> Cou <i>ntry)</i> Maryland	
	<u>g</u>		Usual Residence of Decedent		140									
	arylar show	-	10a. State 10b. County		100.	. City, Town or Lo							10d. Inside C	ity Limits 2 ☑ No
	Ba-f	Director	Maryland Ceci	.1			Colo	ora			45 0			
	with t		10e. Street and Number 149 Colora Road				10f. Zip Code	2191	7		10g. C	itizen of What (
	eath	eral	11. Marital Status	12 Was Dec	edent Ever	n U.S. 13 V	Vas Decedent of H			acity Yes or N	n- 1		nerican Indian,	
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "naturel", or Items 23e or 28a-f show imatic event, It a Madical Expanient matter than the halffied at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F	orces? 2⊠No ive		Vas Decedent of H I Yes, specify Cuba □ Yes 2☑ No	Specify:	, Puerto	Rican, etc.)		Black, Wh		
5-0036	2 hou	ed	15. Decedent's E	ducation			ent's Usual Occup				16b. F	Kind of Busines	ss/Industry	
212	filed within 72 Hygiene. other than "ne ent, I're Medic	Completed	(Specify only highest gi) (1-4or 5+)	(Give	kind of work done of NOT use retired	during most i)	of worki	ng				
21	d with giene ar tha	mo.	Seven Years				Farmer				A	gricult	ure	
2	al Hy f other	Be	17. Father's Name (First, Middle, Las	t)				18. Mothe	r's Name	(First, Middle	, Maidei	n Sumame)		
<u>X</u>	should be filed within and Mental Hygiene. s marked other than umatic event, II's M	2	Oliver	Blakele	У					Elsie	Cur	ry		
Maryland	2 8 8 8		19a. Informant's Name/Relationship Jean Boyd Blakel		fe)		g Address <i>(Street</i> Colora R	_			-	_		
altimore,	es 1 and 2 of Health fitem 27		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [□ Removel from	l l	b. Place of Dispo cemetery, cren	sition (Name of natory or other place	(9)		Date	20c. L	ocation - City of	or Town, State	
Ĕ	Pages ment of ent: If its ury or o		'4 □ Donation 5 □ Other (Spec			West Nottin	ngham Cemet	ery	04/1	5/06	Со	lora, N	Maryland	
Ball	permit. Pag Department Importent: I eny injury o once.		21. Signature of Funeral Service Lice	PALLE	VA CYC	Le	Name and Addrese A. Paterryville	terso	n &				P.A.	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that	caused the c	leath. Do not ent	er the mode of dyin	g, such as	cardiac c	or respiratory	arrest,	7.00_	Approximat Interval Bet	te tween
E	Physician		Immediate Cause (Final disease or condition			the he		luno					Onset and	Death
	/Medical		resulting in death)	Due to	(or as a con	sequence of):							1094	
	Examiner	_	Sequentially list conditions,	b B(Oblitera	ns v	ofth.	obstru	dng	Premy	2 44	ews_
	ed isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a con	sequence of):					'	•	/	
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to	(or as a con	sequence of):								
8760	ysiciar e buri	dicail	(d										
9		Medi	IF FEMALE.								1			
Вох	th ceu tendir r use	an/\	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or 1☐Live	utcome of pre		Ectopic pregnancy	,				23d. Date of d		Year
	The law requires that the death certifinate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Preg 9□Unki	nant at time nown	of death 5	Other (specify)					MONTH	Day	real
P.0	res that the igned by be detact	y Ph	Part II. Other significant conditions	contributing to	death but not	resulting in the u	nderlying cause giv	en in Part I.		23e. Did	tobacco	use contribute	to the cause of o	death?
Records,	quires n sigr ald be	d by	Cerebrovosa	ler de	Seak)				1 🗆	Yes 2	2 2 N o 3 □ I	Probably 4 □t	Unknown
00	s been si should!	Completed	Africal Filoni	1 (when						24a. Wa		24b. Were	autopsy findings	available
	The law ate has page 2:	mo								auto perf	ormed?	death	completion of c es 2 No	ause of
Viita		0	25. Was case referred to medical					26. Place	of Death	(Check only		0 1010	33 20140	
	ysici is cer direc	0 8	examiner? 1 ☐ Yes 2 ☑No	Hospital: 1	Inpatient :	2 ER/Outpatien	t 3 DOA Oth	er: 4 Nui	rsing Ho	me 5□Res	idence	6 ☐Other (Sp	pecify)	
Division of	Attending Physician: sr death. ector: After this certification in the funeral director.	Certification: T	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation		of Injury nth, Day Yea	28b. Time of Injury	28c. Injur Wor M 1	y at k? Yes 2 □ N		28d. Describe	how inju	iry occurred		
S	or Attsno after death Director: in by the	fica	3 ☐ Suicide 6 ☐ Could not	28e. Plac	e of Injury - /	At home, farm, str							Rural Route Num	nber,
á	al or safter	Serti	4 Homicide	buile	ding, etc. (Sp	ecify)			Į.	City or To	wn, Stat	(e)		
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	miner: On the	e best of my basis of exan nner stated.	knowledge, death nination and/or in	occurred at the tir restigation, in my o	ne, date and pinion, deat	d place, a	and due to the ed at the time	cause(s date an	s) and manner and place, and di	as stated. ue to the cause(s	s)
	To th within To th	Me	29b. Signature and title of certifier	10 4			29c. Licens	e number			29d. Da	ate signed (Moi	nth, Day, Year)	
			Lamph K.	Werd	ner /	fras	DC	0443	:73		4	1/12/20	006	
	5		30. Name and address of person who Joseph K. Weidne:					y, Ris	sing	Sun, M	[ary]	land	21911	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 4 2006	32. Klasus	Registrar's S	ignature								

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRIL ELEVIAN SMITH BURRIS 2006 8:59 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 12296 Still Pond Rd. Still Pond Kent If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Sept 2 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2X F Director 220-32-9161 66 Yrs. 1939 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23e or 28a-f show traumatic event, the Medical Exam. or traust by notified at 1 ☐ Yes 2 1 No MD Director Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24840 Montebello Lake Rd. 21678 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Lawn Care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Fages 1 and 2 should be file Department of Health and Menkal Hy Important: If Itam 27 Ia marked oth any injury or other traumatic evan pace. J. Earl Smith Lola Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Brown (daughter) 12296 Still Pond Rd. Still Pond, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Chester Cemetery 4/26/06 Chestertown, MD. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 23a. Part Prite the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Brain 10 mo metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Monary 10 mo Physician/Medical embolism IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No has certificate or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes → No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide within 24 hours a To the Funaral L 29a. Certifier 🕬 pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D5 1735 W s of person who completed cause of death (Item 23a) (Type, Print) 12 hurch Hill Rd 6602 Registrar's Signature °6° 2006 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mai	Cei	rtificate of			eg. No)6 1	3 6
F	a Disconing	dt so	1. Decedent's Name (First, Middle, Last)					2. Dete of Deet Month		Year 3. Ti	ime of Death
	Physici /Medio		Elsie	Virginia	Ca	mpbell		Apri1	5 2	006 2	:30 pm
š	Examir		4e Fecility Name (If not institution, give				4b. City, Town, or L		4c. County	of Death	
14.			Heritage Harbou				Annapoli:			Arunde	
	Funeral Director		003-20-3372	1	(In yrs. last birthday) 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 22	, 1919	9. Birthplace (S Country) New Har	mpshire
	nyland show		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town or Lo	ocation					ide City Limits
	er death with the Marylan items 23a or 28e-f show net must be notified at	cto	MD Anne Ar	undel	Annapo						Yes 21 No
	ith th	F	10e. Street end Number			10f. Zip Code		1	0g. Citizen of W	/hat Country?	
	ath v	rai	2700 South Haven			214				SA	
020	ਰ ਕ	by Funeral Director	11. Marital Status \[\include{\sqrt{Never Merried}} 2 \sqrt{ Married} \] 3 \sqrt{ Widowed} 4 \sqrt{ Divorced}	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates:	ver in 0,5.	was Decedent of N If Yes, specify Cub 1 ☐ Yes ※XXNo	Hispanic Origin? (Sp can, Mexican, Puerto Specify:	Rican, etc.)		e - American India k, White, etc. White	
Ö	"naturel",	B	15. Decedent's Educ		16a. Deced	dent's Usual Occup	petion	ring	16b. Kind of Bu	siness/Industry	
21215-0020	within 9ne.	Completed by	(Specify only highest grade	College (1-4or 5+))	king of work gone DO NOT use retire ekeeper	during most of worked)	ang	Clean	ina	
5	filed Hygi fher mt,		unknown 17. Father's Name (First, Middle, Lest)		nous	скесрег	18. Mother's Nam	e (First, Middle, N			
Maryland	D # D .	To Be	Ralph Ira Campbel	11			Elsie	C. Hybs	ch		
ary	d 2 should th and Men 7 is marke treumatic		19a. Informant's Name/Relationship (Type		19b. Mailir	ng Addrass (Street	t and Number or Rur	al Route Number	City or Town,	State, Zip Code)	
	and 2 salth a n 27 li		David Campbell (I	Brother)			eet, Ports	smouth,	NH 0380	1	
Baltimore,	E T E		20a. Method of Disposition XXX Burial 2 □ Cremation 3 □ R 4 □ Donetion 5 □ Other (Specify)	emoval from State	20b. Place of Dispondentery, cremetery, cremetery		J =	4/10	20c. Location - 6 Manches	City or Town, Sta ter. NH	ite
alti	in the state of		21. Signature Funeral Service Licen	7 6			ess of Facility y Funeral			cor, m	
m	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen	- 1	+ 15 g. C	m			ely Avenue			D 21401	
	100		23a. Pert1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the	ne death. Do not ent					Appro	ximate al Between
1	Physician /Medical			6010	\	Acter	disea	41		Onset	and Death
	Examiner	<u>.</u>	resulting in death)	Di	ue to (or as a conseq	uence of):					A.
	bed is	nine	_ b	Gen	unl c	1e61/1)	У			Mo	11645
	al-trai	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Di	ue to (or as e conseq	juence of):					P
68760,	tificate be executed g physician and as the bunal-transit	edical	triat initiated events	Ane	M) M Je to (or as a conseq	uence ofi:				0(0	166
98	tificat ng phy as th	8	resulting in death) Last		Je to (or as a conseq	derice or).					
	th cer endin r use	ary	d								
	deat he att ed fo	Physician/M	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23b. Did to	bacco use con	tribute to the ca	iuse of death?
, P.O.	that the death ce led by the attendii detached for use							1 □ Ye	s 20No	3 ☐ Probably	4 🗆 Unknown
Records,	The law requires ate has been sign page 2 should be	ed by						24a. Was er	n autopsy	24b. Were auto available	opsy findings
ပ္သ	aw red	Completed						perion	ned ?	completion of death?	n of cause
č	The la	Ë						1 V	a 2016 .	1 ☐ Yes	2□ No
ita/	entifica ctor,	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	e)		
<u></u>	hysic his co	2	1 Yes 2 No	Commence of the same	2 ER/Outpatien	IL SEL DOM		ome 5 Reside			
n c	Ing P	<u>5</u>	27. Manner of Deeth 1 ☑ Naturel 5 ☐ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time of Injury	Wo	ny at ork?]Yes 2 □ No	28d. Describe ho	w injury occurre	∌d	
Division of Vital	Attending Physicien: r death. ector: After this certific. by the funeral director,	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury	/ - At home, farm, str			28f. Location (Sti	reet and Numbe	er or Rural Route	Number,
<u>≥</u>	al or A s after al Dire ed in b	Cert	4 ☐ Homicide determined	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town			
	To the Hospital or Attending Physicien: The law requires that the death cer within 24 hours after death stores within 25 thours after death stores. To the Luneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	edical Certification:	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of re: On the basis of ex	xamination and/or inv	occurrad at the til vestigation, in my o	me, date end place, opinion, death occur	and due to the ca red et the time, da	use(s) and mar ate and place, a	nner as stated. Indidue to the ca	use(s)
	To the Within To the comple	Me	29b. Signature and title progratifier			29c. Licens	se number	29	9d. Date signed	(Month, Dey, Ye	ear)
	->-0		N. W.	1n		134	19/8		4-6	1-200	6
			30. Neme end address of person who cor	mpleted cause of dea	th (Item 23e) (Type,	Print)	110 1	Aav	2 RD	-200 -200 	5.
			Nadel Towa	KU11 41	100 M	Tch,1111	110 120	(73)	6 170	20	1716
	Sta Begistr		31. Date filed (Month, Day, Year) APR 1 1 28	32. F gistrar's	s Signature	and a					

			1 - For State Registrar	State of Marylar		artment of rtificate of		nd Mental H	ygiene Reg. No	000	13162
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Elizabeth H. Ca				-	2. Date of I April		^y 2006	3. Time of Death 1350 M
	Examir		4a. Facility Name (If not institution, give s Anne Arunde1 Me		er	4b. City, Town, Annapo		Death		County of Death	
- 4	Funeral Director		5. Social Security Number 6. Sex 214-38-0537	7. Age (In yrs.	91 Yrs.	If Under 1 Yea Months Day:		Min. (Month,	Day, Year)	9. Birth Cou 914 Mar	place (State or Foreign ntry) yland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, if a Madical Exeminal must be notified at once.	Funeral Director	10a. State 10b. County Maryland Anne Ar 10e. Street and Number 1442 Tyler Ave		I.S. 13.	101. Zip Code 21403		n? (Specify Yes or I Puerto Rican, etc.)	US	tizen of What Cou SA 14. Race - Amen Black, White,	can Indian,
d 21215-0036	filed within 72 hours af Hygiene. sther than "natural", or ent, its Madiesi Exam	Completed by	3 Widowed 4 Divorced 15 Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 4th 17. Father's Name (First, Middle, Last)	If Yes, Give Year or Dates:	16a. Dece (Give life.	dent's Usual Occi kind of work don DO NDT use retir	upation e during most of ed)	of working s Name (First, Midd	Pr	Specify: B1 ind of Business/Ir ivate mily Sumame)	
Maryland	should be nd Mental marked c	To Be	Thomas Jones		19b. Mailii	ng Address (Stree		Iary A. (o Code)
	ages 1 and 2. It of Health a: If Item 27 is		Mary Brown (Step 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R	2 9 2	Place of Dispo	Tyler Tyler That or Name of the plant of t	Ace)	Annapoli Date -14-06	20c. L	dd. 214 ocation City or T endship	own, State
Baltimore,	permit. Pa Departmer Important any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		, W	Name and Add M • Rees	ress of Eacility	ons Mort Annapoli	uary	7, P.A.	
. The	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart/failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deale cause on each line. Con GET Due to (or as a consec	th. Do not ent		ring, such as ca				Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	e TERV	FACT!	13 Em 3 E			YEAR).
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending p completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	⊒Ectopic pregnan ⊒ Other (specify)	су			23d. Date of deliving Month	ery Day Year
rds, P.	quires that n signed by	ed by Pr	Part II. Other significant conditions con	-	sulting in the u		Iven in Part I.				he cause of death?
Division of Vital Records,	The law requir cate has been si page 2 should	Completed	DEMENTIA	P.			ay at a		opsy formed?	prior to co death?	opsy findings available impletion of cause of
f Vita	Physician: The this certificate he al director, page	To Be	25. Was case referred to medical examiner?	ospital:patient 2 [] ER/Outpatier	nt 3 DOA	thor	of Death (Check only		6 ☐ Other (Specif	(y)
sion o	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification:	27. Manner of Death latural	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W		28d. Describ			
DIX	oitaí or At urs after d srai Direct illed in by		4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)			City or T	own, State		
	the Hosp nin 24 ho the Fune npletely f	fedical	one) 2 Medical Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deatl	vestigation, in my	opinion, death	place, and due to the occurred at the time	e, date and	d place, and due to	o the cause(s)
)	To with To Con	Σ	12 /1	ND)514	37		te signed (Month,	
			30. Name and address of person who co	RCY IBLTE	SYE	Print) AAM	2001	1 MEDICA	H PI	ANNA PRKWITY	12006 MD 21401
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 20	32. Jegistrar's Signa	ature	and I					

			1 - For State Registrar	State of Maryla		artment of rtificate of			giene () ()	6 13163	3
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	3. Time of Death	h
ı	/Medic		Harold W.	Cumbo					8, 2006	6:00 p	М
9	Examir	ier	4a. Facility Name (If not institution, give : Manor Care- Silve			Silver	or Location of Dea	ath	4c. County of	of Death Gomery	
4	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hi	s. 8. Date of Bir	th	Birthplace (State or Fore	eign
ı	Director		536-16-4294	^{3M 2□F} 86	Yrs.	Months Days	Hours Mi	April	1, 1920	Oregon	
	pu k		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	ecation				10d. Inside City Lim	nite
	daryli f •ho	5								1 ☐ Yes 2 🚰	
	28a-	Director	Maryland Montgome 10e. Street and Number	ry	ilver S	10f. Zip Code			10g. Citizen of W	/hat Country?	_
	h with	ai D	8402 11th Avenue			209	03		USA	•	
1215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or Items 23s or 28s-f ehow event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married ÆMarried 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cul	ban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)		e - American Indian, k, White, etc. White	
ָ ה	72 ho	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual Occu	pation during most of w	odkina	16b. Kind of Bus	siness/Industry	
7	ithin 18.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	life. I	DO NOT use retire	ed)	Ol King	TI -2		
7	filed w Hygier Ather th		17. Father's Name (First, Middle, Last)	5+	L10	rarian	18 Mother's N	ame (First, Middle	L	ation	
Maryland	should be f nd Mental h marked of matic ever	To Be	George Cumbo					e Hoekem		·/	
, Mar	and 2 shi		19a. Informant's Name/Relationship (Ty, Dorothy Cumbo/ Wif					Ru <i>ral Route Numb</i> Lver Spri			
gaitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic and DEG.		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □R 4 □Donation 5 □ Other (Specify)	emoval from State	-	sition (Name of matory or other pla .11 Cemet	. AL	Date Dril 13, 2006	20c. Location - 0 Wilkes-B	City or Town, State	
galt	permit. Departri Importa any Inju		21. Signature of Funeral Service License	** O	2 4	Name and Adde	ess of office ersity Bl	s Funera vd, W, S	l Home I	inc oring, MD 209	01
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de						Approximate Interval Between	
	Physician	8	Immediate Cause (Final disease or condition	Dementia						Onset and Death	
	/Medical	1. 1	resulting in death)	Due to (or as a conse							
	Examiner	_	Sequentially list conditions,	Atrial Fibr		n					
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
,	icate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
8/60,	ysicia e bur	dicall		ı							
0	ng ph as th	Medi	IF FEMALE:								
X Q Q	death certificate be executed e ettending physicien and d for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3 □	Ectopic pregnand	су		23d. Date Mon	of delivery th Day Year	
	the de y the e tched f	ysic	1 Yes 2 No	4□Pregnant at time of 9□ Unknown	fdeath 5□	Other (specify)			1000	in Day Tour	
ŗ.	that ed b deta		Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause g	ven in Part I.	23e. Did t	obacco use contri	bute to the cause of death?	
g	requires een sign nould be	d by	Psoriasis					10	Yes 2 No	3 ☐ Probably 4 ☐ Unknow	wn
ecora	> 0 0	piete						24a. Was	an 24b. W	ere autopsy findings availal	ble
Ţ	o = 0	Completed						autor perfo	rmed? de	rior to completion of cause o eath? □ Yes 2□ No	ΣĬ
<u>a</u>	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					eath (Check only o			
5		၉	1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2		3 DOA		Home 5 ☐ Resid			
Ē	ing When	io.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ıryat ork?]Yes 2 ∐No	28d. Describe	how injury occurre	d	
DIVISION	al or Attending Phys atter death. I Director: After this d in by the funeral di	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, farm, str			28t. Location (Street and Numbe	r or Rural Route Number,	
<u> </u>	al or / s after if Dire	Certification:	4 Homicide determined	building, etc. (Spec	cify)	,,		City or To	vn, State)		
	To the Hospital within 24 hours a To the Funeral I completely filled	ledicai C	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death	occurred at the t vestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, a	iner as stated. nd due to the cause(s)	
	To the To the Complet	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	(Month, Day, Year)	
	10		1/anno H	w		05	3235	14.	April 10	, 2006	
	0		30. Name and address of person who co			Print)		20707			
			Darryl Hill, M.D	13635 Balti		enue, La	aurel, Mi	20/0/			
	Sta Registr		31. Date filed (Month, Pay, Year) APR 12 20	32. Jegistrar's Sign	nature	and I					

			1 - For State Registrar 1. Decedent's Name (First, Middle, La	State of M	larylan		rtmen tificat			nd M	2. Date of Dear	eg. No.		3 6
	Physici /Medio Examir	cal	Elizabeth Webl	Cric	hton		4b. Cîty,	Town, or	Location of	Death	April '	7)6 Inty of Deat	11:45 p
		ier	Brooke Grove Nur 5. Social Security Number 6. S	rsing Home	•	ast birthday)	Sand:	y Sp	ring	24 Hrs.	8. Date of Birth		9. Birt	tgomery hplace (State or Foreig
L	Funeral Director			□M 25€F	87	Yrs.	Months	Days	Hours	A dise	Jan. 7,	1919	Floi	rida
	e Maryland	ctor	10a. State 10b. County Maryland Montgor	mery	10c. City	, Town or Lo Olr	cation							10d. Inside City Limit 1 ☐ Yes 2 N
	h with th	ai Dire	10e. Street and Number 18532 Meadowland	d Terrace			10f. Zip	Code 2083:	2		1	0g. Citizen	of What Co USA	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department if item 27 is marked other then "naturel", or itema 23e or 28e-f show enything on the returnation of the result of the result of the notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ X Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes If Yes, Give Year or Dates:	? No		Vas Deced f Yes, spec			in? (Spe Puerto F	cify Yes or No- Rican, etc.)		Race - Ame Black, White ecifyWhit	
21215-0036	nin 72 ho on "natur Medical	pieted	15. Decedent's E (Specify only highest gra	ducation ade completed) College (1-4or	5+)	16a. Deced (Give life. L	lent's Usua kind of wo DO NOT us	al Occupa rk done d se retired,	ition uring most	of workin	ng	16b. Kind o	f Business/	Industry
IZ pue	l be filed with	Be	17. Father's Name (First, Middle, Last, Harold Webb	4	0.,	Admi	inist	rato			(First, Middle, I			Government
Maryland	nd 2 should alth and Me 27 ie mark ir treumatio	To	19a. Informant's Name/Relationship (r or Rura	Route Number ace, Ol			
Baltimore,	Pages 1 and of Heigher I if I item ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		a a	lace of Dispo emetery, cren ropolita	natory`or o	ther place		pril 20	тт,			Town, State Virginia
Balt	Departi Departi Importa eny inju		21. Signature of Funeral Service Licer	1	_	F1 50	Name ar anci O Un	g Addres	s of Facility	ins Elvd	Funeral , W, Ei	Home lver	Inc.	g, MD 2090
	Physician /Medical Examiner	Examiner	22. Part1. Enter the Isease, or om shock, or heart rilure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, Isaam of the Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Congest Due to (or a b. Lue to (or a c. Due to (or a	cive F saconseques saconseques	Heart I								inferval Between Onset and Death Days
.O. Box 68760,	to death certificate be executed the attending physicien and hed for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1	2 Fetal	death 3	Ectopic pi Other (sp					23d.	Date of dei Month	ivery Day Year
1	requires that the de een signed by the a nould be detached t	ρ	Part II. Other significant conditions of	contributing to death	but not resu	ulting in the u	nderlying o	ause give	on in Part I.			baccouse d		the cause of death?
Il Records,	The law ate has b page 2 st	Completed									24a. Was a autops perform	ned?	tb. Were au prior to death? 1 Yes	itopsy findings availab completion of cause of 2 ☐ No
Vital	Physicien; The this certificate h rat director, page	o Be	25. Was case referred to medical examiner? 1 □ Yes XX No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatien	it 3 🗆 DC	Othe			Check on or ne 5 ☐ Reside	-T.	Other (Spe	cifv)
Division of	ding Ph After th funerat	Certification: T	27. Manner of Death 1 12 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Ir	aý Year)	28b. Time of Injury ome, farm, str	М			No 2	28d. Describe h	ow injury od	curred	ıral Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medicai Ce	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exal one)	nysician: To the bes miner: On the basis and manner s	of examina	wledge, death tion and/or in-	n occurred vestigation	at the tim	ie, date and pinion, deat	d place, a	and due to the co	ause(s) and ate and pla	i manner as ce, and due	stated. to the cause(s)
	To the complex	Me	29b. Signature and title of ceptifier 30. Name and address of person who				Print)	D55	694				gned (Monta	h, Day, Year) 2006
	Sta	ate	Alok Mathur, M 31. Date filed (Month, Day, Year) APR 19		Olney tran's Signa		onsvi	lle,	Olney	у, М	D 20832			

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

30. Name and address of person who completed cause of ath (Item 23a) (Type, Print)

LT

TILLEY

MC

USNR

32. Segistrar's Signature

For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

3. Time of Death

Birthplace (State or Foreign Country)

Pennsylvania

10d. Inside City Limits

1 ☐ Yes 2 🔀 No

3:04

Reg. No.

Day

2006

1923

USA

4c. County of Death

MONTGOMERY

14. Race - American Indian. Black, White, etc.

Specify.White

2. Date of Death

Month

15,	20c. Lo	cation	· City o	r Towi	n, State	
6	Arli	ingt	ton,	V:	irgi	inia
uneral W, Si	Hom lver	ne :	Inc. orin	ıg,	MD	20901
espiratory ar	rest,			l Ir		nate Between nd Death
	2		ite of de onth	,	ay	Year
23 <i>e</i> . Did to	obacco us	se con	tribute t	o the	cause	of death?
1 🗆 Y	es 2X	ON	3 🗆 P	robab	ly 4	Unknown
24a. Was autop perfor		24b.	Were a prior to death?	comp	y find(n letion o	gs available cause of
Check only o	пе					
5 ☐ Resid	ience 6	Oth	ner (Spe	ecify)		
d. Describe h	iow injury	occur	red			
Location (S City or Tow	treet and m, State)	Numi	oer or R	ural F	loute N	um <i>ber</i> ,
d due to the d	cause(s)	and m	anner a	s state	ed.	-/.>

10/2006

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Registrar DHMH 17 Rev 1/2001

State

DRAKE H.

31. Date filed (Month.

0101233383 (VA)

Physicia	ın	- Stata Registrar Amend Item 1. Decedent's Name (First, Middle, La RONALD HENR	st)				2. Date of Death Month APRIL 14	Day Year	3. Time of Death 6:33am
/Medic Examin	_	4a. Facility Name (If not institution, given CIVISTA MEDICAL	e street and number)	OIV	4b. City, Town, o	r Location of Death		4c. County of Dea	th
uneral irector		5. Social Security Number 6. S 217-34-0713 Usuaf Residence of Decedent	T7 14 6 7 5	yrs. last birthday, 9 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, IAN - 11,		thplace (State or Foreignuntry)
28a-f show cotified at	tor	10a. State 10b. County MARYLAND CHA	RLES	. City, Town or Lo	AN HEAD				10d. Inside City Limit
a or 28; Lbe rot	Direc	10e. Street and Number 4163 BARRETT P	TACE		10f. Zip Code 20640)	10	g. Citizen of What Co	ountry?
in result and welled rygelies in the 23s or 28s-1 show them 27 is marked other than "natural", or liems 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at	by Fur	11. Marital Status 1 Never Married ZXIXMarned 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? Mayes 2 No if Yes, Give Year or Dates:	-		lispanic Origin? (Spec an, Mexican, Puerto P	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
"natura ledical	Completed	15. Decedent's E (Specify only highest gra	ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	nation during most of workin	g 1	6b. Kind of Business	/industry
marked other than	a	Elementary/Secondary (0-12) 9 17. Father's Name (First, Middle, Last	College (1-4or 5+)		CERY MAN			A & P (GROCERY
is marked aumatic e	ို	Henry HANRY CLAY DA		40h Maii	an Address (Street			WHEELEF	
tem 27 Is r		Delores Joan Dani Joan Danielson	elson/wife SPOUSE			and Number or Rural TT PLACE,			MD 20640
Importent: If Its eny Injury or o once.		20a. Method of Disposition 1	Removal from State METRO nsee MO	POLITI 0478	Matory or other place AN CREM! 2. Name and Addre RAVMOND	ATORY 4-2 ss of Facility FIINER A L	20-06 A	E. P A	
ed by the attending physician and unit of the attending physician and obtached for use as the burial-transit of the physician and unit of the physic	ical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor	age iseque de of):	I Vo	arices			
y the attending I Iched for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pro 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetaf death 3	⊒Ectopic pregnancy ⊒ Other (specify)	1		23d. Date of del Month	livery Day Year
s been signed b should be deta	ed by Pł	Part If. Other significant conditions of	contributing to death but not	resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death? robably 4 □Unknov
page 2	Complet						24a. Was an autopsy perform	ed? prior to death?	utopsy findings availab completion of cause o
r this certifice ral director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ₺No	Hospital:	2 ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing Hom		nce 6 Other (Spe	c(tv)
		27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28a. Date of Injury (Month, Day Yea	At home, farm, st	M 1 □	y at 2i k? Yes 2 □ No	8d. Describe hov	v infury occurred set and Number or Ri	
Afte	=======================================		building, etc. (b)						
To the Funeral Director: After the completely filled in by the funeral to	Medical Certification:	29a. Certifier (Check only one)	nysicien: To the best of my miner: On the basis of exar and manner stated.	knowledge, deal nination and/or in	th occurred at the tire execution, in my o	ne, date and place, a pinion, death occurre	d at the time, da	te and place, and due	s stated. to the cause(s)

			Please	State of M						•	•	
			For State	State of Ma	aryland			т неакп а of Death	ına men		ZHUb	13167
	-		Registrar 1. Decedent's Name (First, Middle, L	acti		Cer	illicate (Dealli	2 [Re Date of Death	g. No.	3. Time of Death
	Physic	an		Durant						Month,	Day Year	2,20 P.
	/Medi		Gladys M. 4a. Facility Name (If not institution, g				4b. City, Tow	m, or Location of	of Death		4c. County of De	
	Examir	ier	Doctors Commun				_	nham			Prince	Georges
l l	Funeral			Sex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Y		24 Hrs. 8. E	Date of Birth Month, Day,	9. B	irthplace (State or Foreign
l l	Director		578-07-0407	1□M 2\\ F	9	3 Yrs.	W.C.II.IO	.,,	Ma	y 26	,1912 W	Jash.,DC
	pus		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lor	ation					10d. Inside City Limits
	Aarylan febow	٥	MD. PG			Canit	ol He	ights				1 Yes 2 □ No
	the 1	Funeral Director	10e. Street and Number		l .	Cupic	10f. Zip Co			10	g. Citizen of What (Country?
5	3a o	O is	108 Quire Ave	nue			20	743		1	United S	States
1	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13. V	Vas Decedent Yes, specify	of Hispanic Orig Cuban, Mexican,	gin? (Specify , Puerto Rica	Yes or No- n, etc.)	14. Race - An Black, Wh	nerican Indian, lite, etc.
0 5	o after	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 [X] If Yes, Give			☐Yes 212				Specific	
4	.0036 hours after death with the Maryland tural', or Items 23a or 28a-1 show all Examinar must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		16a Dassa	ent's Usual O	acupation.			6b. Kind of Busines	hite
/ ;	n 72 n	lete	15. Decedent's (Specify only highest of	grade completed)		(Give	kind of work d OO NOT use re	one durina most	t of working		TOD. KING OF DUSINES	Silidustry
1 /	d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Neve	r Wor	ked			None	
\circ	other,	BeC	17. Father's Name (First, Middle, La	st)				18. Mother	r's Name (Fir	rst, Middle, M	faiden Surname)	
11	Variate of the control of the contro	ToE	Louis R. Wood	Ē				Mat	tie D	eakin	ıs	
7	Marylan 1d 2 should be 1th and Mental 27 Is marked of traumatic ev		19a. Informant's Name/Relationship			19b. Mailin	g Address (St	reet and Numbe. Ouire	or Or Rural Ro Aven	u <i>te Number</i> , u e	City or Town, State	, Zip Code)
	and and ealth m 27	1	Barbara A. Day	/is/siste		-law	Cap	itol H	eight Date	S, MI		
8	ges 1 Fof H or off		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3				sition (Name of atory or other	,				
<i>S</i> :	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 ehov any piqury or other traumatic event, its Medical Examinat mouth an united. any ange.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Liq		Ma.			Cem. 4			Cheltenh Edwards	
0	Bai permii Departii Impol		21. Signature of Porteral Service Lit.	Museum	1) (2.55			17-18-0E- 45	0.00		,MD.20746
	NISELVI		23a, Pont. Enter the disease, or co	emplications that cause	d the death.							Approximate Interval Between
	Physician		lm ediate Cause (Final			DUF	75 CM	CAR	12	cci	DENT	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	ence of):		-,,,,_	/1		DENT	
	Examiner		Sequentially list conditions	BRE	75	7	CA	NCE	R			
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as			~					
3	60, be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as		OT (7					
	60, be execu icien and burial-tra	a E			,							
	Box 687 Jeath certificate ettending physi	edic		d								
	Box 687 sath certificate ettending phys for use as the	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Catania progr	2001			23d. Date of o	•
	death death	icia	in the past 12 months? 1 \(\sum \) Yes 2 \(\overline{\ov	4☐ Pregnant a			Ectopic pregr Other (speci				Month	Day Year
	P.O.	Physician/Medic	9 ☐ Unknown							00- 014		to the course of death?
		þ	Part II. Other significant condition:	s contributing to death I	but not resu	lting in the ui	iderlying caus	e given in Part I.				to the cause of death? Probably 4 □Unknown
	COCC W requir been si should	Completed										
	Rec e law has b	mpi				•				24a. Was an autopsy perform	ned? death	autopsy findings available o completion of cause of ?
	Vital Rec sician: The lav certificate has rector, pege 2		25 M	P.	-		_	00.71		1 ☐ Yes 2	! (XNo 1 □ Y	es 2K No
;	Vit slcia certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:	ient 2 🗆 F	R/Outpatier	t 3 DOA		of Death (C)		nce 6 ⊡Other (S _i	necify)
,	g Phy g Phy er this ieral o		27. Manner of Death	28a. Date of Inj	ury	28b. Time of		Injury at Work?			w injury occurred	
	ndin ath.	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	tion		,,	М	1 ☐ Yes 2 ☐ I	No			
	Division of Vital Records, to attending Physician: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be to a fine by the funeral director, page 2 should be to a should be t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	288. Flatte UI II	njury - At hor etc. (Specify		eet, factory, or	fice	28f.	Location (St. City or Town	reet and Number or , State)	Rural Route Number,
	Dital of urs af											
	Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical		Physician: To the besi caminer: On the basis of and manner s	of examinat							
	o the	₹	29b. Signature and title of certifier				29c. L	cense number		25	9d. Date signed (Mo	nth, Day, Year)
	FSFO		1	/ (-D	581	82	_ /	4-13	-2006
		1	30. Name and address of person w	no completed cause of	death (Item	23a) (Type,	Print)	0.	V . 1 -	6	- 4-0	11k 2000
	7		Cecil D. Georg	e MD	7305	-A /	tamove	er rain	cevay	C710	eenbelt	140 20170
	St Regis	ate	30. Name and address of person we Cecil D. Georg 31. Date filed (Month, Day, Year) APR 2 6 20	2. Regist	trar's Signat	ure Son	13					
	1.0913	100	71116 1160	JUU MANAGEMENT	,	100						

			1 - State Registrar	State of Marylar		artment of H rtificate of I		_	4000	5 13168
		П	Decedent's Name (First, Middle, La	st)				2. Date of De		3. Time of Death
	Physici /Medio		MARGARET]	ESTEP			Month APRIL		Year 06 12:00P M
	Examin		4a. Facility Name (If not institution, giv SPRINGBROOK NUF	e street and number)		4b. City, Town, or SILVER	Location of Death SPRING	TIT IVEL	4c. County of	
	Funeral Director		5. Social Security Number 6. S 579-84-0823	Sex 7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					MARCH	27 1939	MARYLAND
	arylan show	_	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	8a-f	Director		GEORGE'S	BOWIE	·				1X Yes 2 □ No
	a or 2	ā	10e. Street and Number	OTDI DOAD		10f. Zip Code	0		10g. Citizen of W	•
	ns 23	Funerai	13030 FLETCHERT 11. Marital Status	OWN ROAD 12. Was Decedent Ever in U	J.S. 13. V	2072	.U ispanic Origin? (Spe	acify Yes or No	U.S.A	- American Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than *natural*, or items 23a or 28a-f show event, the Modical Exercities must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 □ Yes 2 🌠 No	n, Mexican, Puerto Specify:	Rican, etc.)		White, etc. BLACK
21215-0036	72 hou		15. Decedent's E	ducation	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Bus	iness/Industry
21	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	KING OF WORK GONE O DO NOT use retired	during most of work)	ing		
2	Hygien Hygien ther th	Con	8th		HOUSE	WIFE			PRIVA	
Maryland	S = 0 >	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name		Maiden Sumame)
$\frac{3}{2}$	should be and Mental amarked o	ဥ	JOSEPH GREET 19a. Informant's Name/Relationship (19h Mailin	n Address (Street	MARY F.		or City or Tourn C	tota Zin Code i
<u>8</u>	and 2 sealth an n 27 ts		AGNES R. CHITTAM				TOWN RD.			
<u>6</u>	-155		20a. Method of Disposition	206. 1	Place of Dispo	sition (Name of natory or other place		Date		ity or Town, State
Ë	Pages nent of I int: if it		1 ဩBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Tremoval nom State		CEMETERY	1	/2006	LANDOVE.	R,MARYLAND
Baltimore,	permit. Page Department Important: it any injury or once.		21. Signature of Funeral Service Licer		22	. Name and Addres		B. JENE	KINS FUNE	ERAL HOME
			23a. Part1. Enter the disease, or com	plications that caused the dear						Approximate
2	Physician		shock, or heart fallure. List only Immediate Cause (Final disease or condition		pulmon:	ary Arres	t			Interval Between Onset and Death
1	/Medical		resulting in death)	a Due to (or as a consec	quence of):					
	Examiner		Sequentially list conditions	b	Dehyd	ration				
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hypovo						
_	and and Il-tran	Examin	that initiated events resulting in death) Last	cDue to (or as a consec						
8/60	icate be executed physicien and s the burial-transit	aiE			(40.100 01).					
280		edicai		d						
O. Box	at the death certific. by the attending pl tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of continuous	al death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Monti	of delivery h Day Year
1	res that igned b	by Pt	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	iderlying cause give	n in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
cords,	w require been sig should by		End Stage Rena	Disease				1 🗆 Y	′es 2 □ No 3	Probably 4 Unknown
Φ	2 2 2	Completed	Decubitus Ulcer	of Sacrum				24a. Was autop	an 24b. We	ere autopsy findings available or to completion of cause of
r =	± ag ag	S						perfor 1 ☐ Yes	rmed? de	ath? ☑Yes 2⊠ No
VItal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death			
ō	Phys rthis raldi	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpatient 2	ER/Outpatien 28b. Time of	28c Injury	4 Nursing Hor	ne 5 ☐ Resid	lence 6 Other	(Specify)
0	nding Phy ith. : After this e funeral c	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work M 1 ☐ Y	? ′es 2 □No		our injury coodinot	•
DIVISION	al or Attending F s after death. I Director: After d in by the funera	ertification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number m, State)	or Rural Route Number,
	Hospite 14 hours Funera tely fille	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death	occurred at the tim estigation, in my op	e, date and place, a sinion, death occurre	and due to the dead at the time, o	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the within 2 to the comple	Me	29b. Signature and title of certifier			29c. License	number	7	29d. Date signed (Month, Day, Year)
	(4)		· Mu			5	6/4,	/	4/11/	06
	De		30. Name an orderss of person who NASREEM KANGO				05 ТАКОМА	PARK,M	IARYLANI	20912
10	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 2006	32. Registrar's Signa						

State of Maryland / Department of Health and Mental Hygiene () 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer **Physician** PAUL TOON APRIL ENG 3:35 A 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GAITHERSBURG

If Under 1 Year | If Under 24 Hrs. 4001 SUNDOWN ROAD MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Yrs. 577-48-8435 79 Director Jan. 25 1927 China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "netural", or Items 23a or 28a-f ehow vent, the Mudical Exactine must be notified at Md. Montgomery Gaithersburg 1 ☐ Yes 2 No Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 4001 Sundown Road United States 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Dano Specify: Chinese Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Convenience Store Owner-Operator 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 of Department of Health ar important: If item 27 ie ony injury or other trea Emiko Eng / Wife 4001 Sundown Road, Gaithersburg, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/15/06 Mt. Carmel Cemetery Sunshine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home murief P. O. Box 5038, Laytonsville, 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTON **Physician** 1/2 LOUR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ur as a consequence of) Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e Ö 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, RENM DISFASE END STAGE 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy 1 Yes 2 No 1 ☐ Yes 2 X No rs after deam.
ral Diractor; After this cermican.
ral by the funeral director, p of Vital Attending Physicien: 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier title of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) April 11, 2006 30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) WHEATON 3941 FERRARA RAYMONO BASS 32. Régistrar's Signature, 31. Date filed (Month, Day, Year) State De Contraction Registrar

			For State Registrar	State of Mar		epartmer <i>Certifica</i> :				giene Reg. No.)6	13170
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De	ath Day	Year	3. Time of Death
	/Medic	al		liam	Easto	<u> </u>	T		April	20 2		1:12 p M
*	Examin	er	4a. Facility Name (If not institution, give s Washington Count	y Hospital		Ha	Town, or Locagersto			Was	shingt	
10%	Funeral Director		220 20 0200	XM 2□F	(In yrs. last birt	Months		dours Mir	Dec. 1	Year 945	West	olace (State or Foreign Virginia
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location					1	0d. Inside City Limits
	Mary B-f sh	tor	WV Morgan		Berke	eley Spi	rings					1 ☐ Yes 2√XNo
	or 28	Director	10e. Street and Number			10f. Zi	Code			10g. Citizen o		ntry?
	e 23a	rai	700 Harrison Aven		er in U.S.	10 Mas D	25411	aia Osiaia?	Coopii, Vocan No	U.S.	A. ace - Americ	and Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural, or iteme 23a or 28a-f show any figury or other traumatic event, the Medical Exam har must be notified at Once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 120 Yes 2 □ No If Yes, Give 1 9 6 Year or Dates: 9 6		If Yes, spe	cify Cuban, M	Mexican, Pue	Specify Yes or No no Rican, etc.)		lack, White,	
9-0	72 hou	ted	15. Decedent's Educ (Specify only highest grade	cation		Decedent's Usu (Give kind of wo			orkina	16b. Kind of	Business/In	dustry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT u	se retired)		UKHIY	Sand	d mini	ng
22	Hygier Hygier Ther ti	CO	17. Father's Name (First, Middle, Last)			Control			ame (First, Middle,			
yland	Mental I	To Be	John Willi		East			Mary	Fra	ances		Burton
, Mar	and 2 shi valth and 27 Ism er traum		19a. Informant's Name/Relationship (Ty) Linda K. Easton	oe, Print)	700	Mailing Addres O Harris	s (Street and SON AVE	Number or R e., Be	Rural Route Number keley Sp	er, City or Tow Orings,	m, State, Zic WV 2	5411
Baltimore, Maryland 21215-0036	Pages 1: nent of He ant: If iten ary or oth		20a. Method of Disposition **Daurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cemeter	Disposition (Na y, crematory or way Ceme	other place)	4/2	Date 4/2006	20c. Locatio Berke		own, State rings, WV
Balt	permit. Departr Importa		21. Signature of Funeral Service License		100522	Helsle 95 Un	nd Address of Ey-Johr ion St.	nson F Ber	uneral Hokeley Spi	ome, Ir rings,	nc. WV 25	411
	¥.		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	calions that caused the cause on each line	he death. Do r							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ACU	ATE A	ENAL	FAIL	URE				Onsel and Death
	/Medical Examiner		resulting in death)	Due to (or as a		,						
*:	ng)	er	Sacuantially ist conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a	· · · · · · · · · · · · · · · · · · ·	05 LIC	NC 100:	217.				
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	+TPER	KALEV	nia					
o,	ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as a		,						
8760,	icate be executed physician and s the burial-transit	dicai			WIM	FIBR	16 CH)	1017			_	
Box 6	Physicien: The law requires that the death certific this certificate has been signed by the attending p rail director, page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal death	3 ☐ Ectopic p					Date of delive	ery Day Year
P.O.	at the by th	hys	9 Unknown	9□ Unknown			, , ,					
	w requires this been signed should be de	ed by	Part II. Other significant conditions cor		not resulting in	THE underlying	•	n Part I.		obacco use co Yes 2 □ No		ne cause of death?
ဝ၁	law requ as been 2 should	Completed							24a. Was	an 24	o. Were auto	psy findings available mpletion of cause of
ř	The ate his page	Com							perfo	rmed?	death? 1 ☐ Yes	2□ No
Vita	icien: Sertific ector,	Be	25. Was case referred to medical examiner?	ospital: 3752			Other		eath (Check only o			
of	Phys r this ral dir	٠ <u>.</u>	1 Yes 2XXo	28a. Date of Injury					Home 5 Reside			y)
on	th. : After	tion	XXNatural 5 Pending 2 Accident investigation	(Month, Day		njury M	28c. Injury at Work? 1 ☐ Yes	2 □ No				
Division of Vital Records,	after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - Al home, fa (Specify)	rm, street, factor	y, office		28f. Location (- City or Tox	Street and Nu vn, State)	mber or Rura	al Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier XXCertifying Physical Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and	, death occurred d/or investigation	l at the time, on, in my opinion	date and pla on, death oc	ce, and due to the curred at the time,	cause(s) and date and plac	manner as s e, and due t	tated. o the cause(s)
	within To the	Me	29b. Signature and title of certifier			29	c. License nu	umber		29d. Date sig	ned (Month,	Day, Year)
			1 Phone	2/-		۵	0062	006		4/21	1200	6
	1241		30. Name and address of pe n who co	1. 0 =0.4	201	SACT.	twi, = i	TATU	STREET			
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 6 2001	34. Registrar	's Signature	Josefi	1/-1161			is to early	7-010 11	1 1 miles 1 mi

			For State Registrar		State o	f Maryla		artment of H rtificate of I		d Mental Hy	giene	6 13171
E	Physicia /Medic		1. Decedent's Nam	e (First, Middle	Peg.	94	FY	ood		2. Date of De Month	_	3. Time of Death
	Examin		Howard	County	, give street and nui General	Hosp		4b. City, Town, or	lumbi	a	Ho: Count	ty of Death Nard
	Funeral Director		5. Social Security N 579-56-3420	0	6. Sex 1 ☐ M 2 🖾 F		s. last birthday, 62 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	lin. (Month, Da	ıy, Year)	9. Birthplace (State or Foreign Country) WASHINGTON, DC
	aryland show	_	Usual Residence of 10a. State	10b. County		10c. C	City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	th the M or 28e-f e notifie	Director	MARYLAND 10e. Street and Nu	MONTGOM mber	ERY	SIL	VER SPRI	NG 10f. Zip Code			10g. Citizen of	What Country?
	death wi	Funerai L	2700 SHANAN	NDALE DRI	12. Was Dec	edent Ever in		20904 Was Decedent of H	ispanic Origin?	(Specify Yes or No		ace - American Indian,
936	urs after el', or Ite	þ	1 Never Mari	_	Armed Fo ied 1 ☐ Yes If Yes, Gir Year or D	2 [X] No ve		If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	Specify:	ierto Rican, etc.)	Speci	ack, White, etc. ify: WHITE
215-003	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene Hylgiene do ther then "naturel", or iteme 23a or 28e-f ehow do ther then "Medical Eranirar must be notified at event, the Medical Eranirar must be notified at	Completed	(Spe		's Education t grade completed)	1 405 5 1	(Give	dent's Usual Occup a kind of work done o DO NOT use retired	during most of i	working	16b. Kind of I	Business/Industry
2	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, Ira M		17. Father's Name		2	1-401 3+)	OFFICE	MANAGER	18. Mother's h	Name (First, Middle	PSYCHIA Maiden Suma	
Maryland	d tal	To Be	JAMES HOLLI						VIRGINIA			IFLOWER
	and 2 shealth and 2 the n 27 te n		19a. Informant's N JOHN F. FLO	OOD, JR./			2700	ing Address (Street a		ER SPRING,	MARYLAND	20+4
altimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: if item 27 le marke any injurementer treumatic once.		20a. Method of Dis 1 🖾 Burial 2 1 4 □ Donation	Cremation	3 □Removal from oecify)	State	cemetery, cre	osition (Name of matory or other place AVEN CEMETE)		Date /13/2006		- City or Town, State PRING, MARYLAND
Balti	permit. I Departm Importer any injut		21. Signature of F	uneral Service	Licensee	170	2 H	2. Name and Addre	ss of Facility I FUNERAL	HOME, INC.		G, MARYLAND 20904
	Pnysician /Medical Examiner		23a. Part1. Enter shock, or he: Immediate Cause disease or conditi resulting in death) Sequentially list or	art failure. List (Final on	a	caused the deceach line. (or as a conse	ath. Do not en		g, such as card	diac or respiratory a		Approximate Interval Between Onset and Death I 9 Years
58760,	icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Und Cause (Disease o that initiated event resulting in death)	mmediate erlying r injury	c	(or as a conse						
P.O. Box (The law requires that the death certific tle has been signed by the attending pl page 2 should be detached for use as s	Physician/Me	IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	months?		oirth 2 ☐ Fe nant at time of	tal death 3 (□Ectopic pregnancy □ Other (specify) _				ate of delivery Ionth Day Year
_	juires tha n signed ald be de	by	Part II. Other sign	rtens	ons contributing to d	eath but not re	esulting in the t	underlying cause giv	en in Part I.	23e. Did 1	_	ntribute to the cause of death? 3 Probably 4 Unknown
al Records,	ysician: The law requir is certificate has been si director, page 2 should i	Completed	Core	onic onary	Reno	il ?	Failu iseas	re e		1 Tes	psy prmed? 2 X No	Were autopsy findings available prior to completion of cause of death? 1 Yes 2
Division of Vital	Physician r this certii ral directo	To Be	25. Was case reference examiner?	(No			ER/Outpatie		er: 4 □ Nursin	Death (Check only of the state	dence 6 □Ot	
ion (ending F sath. or: After he funer	ation;	27. Manner of Dea 1 Natural 2 Accident	5 Pendin investi	gation	of injury ith, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occu	ırred
DIVI	s after de el Direct ed in by t	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 286. Place	e of Injury - At ing, etc. (Spec		reet, factory, office		28f. Location (City or To		nber or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica	Medical	29a. Certifier (Check only one)	1 Certifyin 2 Medicel	g Physician: To the Examiner: On the b and man	e best of my ki asis of examin ner stated.	nowledge, dea nation and/or in	th occurred at the time time time the time time time time time time time tim	ne, date and pla pinion, death o	ace, and due to the ccurred at the time,	cause(s) and m date and place	nanner as stated. , and due to the cause(s)
		Σ	29b. Signature and			mil	، د	29c. Licens		3)		ed (Month, Day, Year)
	3		30. Name and add	dress of person	who completed cause	se of death (Ito	em 23a) (Type	gerd,	Colum	nbia, i	MD 2	19,2006
	Sta Registi		31. Date filed (Mo	APR	1 2 200 ^{32. F}	Regular's Sign	nature #	Aprilio				

			For Stete Registrar		State of M	1arylar			nt of H		nd M	-	giene	005	1	2172
			Decedent's Name (First, Mid	ddle, Last)								2. Date of Dea	-	Yea		Time of Death
	hysici /Media		Ralph	F.			rantz	1				APRIL	19TH	, 2006		18:05 [™]
E	xamir	ner	4a. Facility Name (If not institu		street and number	r)				Location of	Death			County of De		
Fu	neral		MEMORIAL HOSP: 5. Social Security Number	6. Sex		ge (In yrs.	last birthday)	If Und	IBERLA er 1 Year	If Under 2	4 Hrs.	8. Date of Birt		LEGANY 9. B	irthplace	State or Foreign
	ector		217-10-4668	15	M 2□F	90	Yrs.	Month	s Days	Hours	Min.	8. Date of Birt (Month, Da Sep 20), 19°	15 (MD	
land	M H		Usuel Residence of Decedent 10a. State 10b. Cour	nty		10c, Cit	y, Town or Lo	cation					<u> </u>		10d. In	side City Limits
Man	tified	ctor	MD All	egan	y		Cum	berla	nd						1	Yes 2□No
vith th	0 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Funeral Director	10e. Street and Number	N		<u>.</u>		10f. 2	ip Code	1.500			10g. Citiz	en of What	Country?	
eath v	Dark 23	erai	730 Furnace S		12. Was Deceden	t Ever in U	S 13	Was Dec		21502		cify Yes or No	. 1	USA 4. Race - An	nerican Inc	dian
after d		Fun	1 Never Married 2 M		Armed Forces	?] No			ecify Cubar		Puerto F	cify Yes or No- Rican, etc.)	1	Black, Wh	ite, etc.	orari,
Sours :	Exa	d by	3 🖔 Widowed 4 □ Divord		If Yes, Give Year or Dates	· ww				Specify:				Specify: W		
in 72	Aedice	piete	15. Deced (Specify only hig	hest grade	completed)		(Give	kind of v	ual Occupa rork done d use retired)	urina most -	of workir	ng	16b. Kin	d of Busines	s/Industry	
d with	2	Completed	Elementary/Secondary (0-12	"	College (1-4or	5+)	agent						insur	ance o	comp	any
be file	event	Be	17. Father's Name (First, Midd		onta							(First, Middle,				
hould d Mer	marke	ပ္	Ralph Willia 19a. Informant's Name/Relatio				19b Mailie	na Addre	es (Straet a			/lattingly			Zin Code	1
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.	z/ le		William Frantz		son					Roa		Portsi			/A 2	
es 1 a	r oth		20a. Method of Disposition 1 Burial 2 Cremation	n 3 🗆 B	amoval from State	_ 0	Place of Dispo cemetery, crei	natory or	other place)		ate	20c. Loc	ation - City of	or Town, S	tate
treent	Jury o		4 ☐ Donation 5 ☐ Other	(Specify)	2.7	Hille	crest Me			i		1/24/2006	Cur	nberla	nd	MD
Depermine	eny ir		21. Signature of Funeral Servi	(A)	$1 \sim 1$	ΙΔΩΙ	()					me, PA	land l	MD 246	02	
			23a. Part1. Enter the disease, shock, or heart failure. L	or compli	cations that couse	ed the deat	h. Do not ent					Cumber r respiratory ar		WID Z 13	Appr	oximate vai Between
Phys			Immediate Cause (Final disease or condition	a	_Sepsis										Onse	and Death
	dical niner		resulting in death)		Due to (or a		uence of);									2
	4	er	Sequentially list conditions,	· ·	Left 1 Due to (or a	ower	lobe p	neur	onia						2 c	lays
cuted	ransit	Examiner	dary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1.												
, e exe	pnysicien and the burial-transit	EX	resulting in death) Last		Due to (or a	s a conseq	uence of):									
cate t	pnysic s the b	dical														
Certif	been signed by the attending is should be detached for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, outcom-			75-4:-					23	3d. Date of d	elivery	
e deat	ne am	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐ Pregnant a			Other (pregnancy specify)					Month	Day	Year
hetth	detach		9 ☐ Unknown Part II. Other significant cond	itions con		but not res	ulting in the u	nderlying	CAUSE GIVE	π in Part I		23a. Did to	phacen us	e contribute	to the cau	se of death?
uires i	ed bi	d by					•						es 25		Probably	4 Unknown
a s	2 shot	plete										24a. Was		24b. Were a	autopsy fir	ndings available
Thei	page 2	Completed						-					med? 2 No	death?	completi s 2 □ 1	on of cause of
iclan	director, page	Be	25. Was case referred to medi examiner?		ospital:		7/0		Othe	~		Check only or				
2 4	E 768	고 :	1 ☐ Yes 2 ☐ No 27. Manner of Death		28a. Date of Inj (Month, D		ER/Outpatier 28b. Time of		28c. Injury	at Nurs		ne 5 🗌 Resid 8d. Describe h			ecify)	
at di	by the funeral	atio	2 - 100.00	stigation	(Month, D	ay rear)	Injury	М	Work 1 □ Y	? 'es 2 ☐ N	0					
or Att	in by t	Certification;	3 Suicide 6 Cou 4 Homicide dete	mined	28e. Place of in building, e	njury - At ho atc. <i>(Specif</i>	ome, farm, str y)	eet, facto	ry, office		2	8f. Location (S City or Tow	itreet and m, State)	Number or I	Rural Rou	e Number,
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours either death.	completely filled in		29a. Certifier 12 Certif	ying Phys	ician: To the bes	t of my kno	wledge, death	occurre	d at the time	e. date and	place, a	nd due to the d	cause(s) a	and manner a	s stated	
hs Ho	pietely	edicai	(Check only 2 Medic one)	al Examir	er: On the basis and manner s	ot examina	tion and/or in	vestigatio	n, in my op	inion, death	occurre	d at the time, o	date and p	place, and du	e to the c	ause(s)
To the	com	ž	29b. Signature and title of certi	fier	\cap	1		1 2	c. License	number				signed (Mor	nth, Day,	(ear)
3			1 Lebius	~ch	o /.	De	min.	Y	D	14865			APR	il 2	1 3	2006
(0		30. Name and address of personal BARRERA, ROBU		IO .T., M.	. D	500 MEI	MORT	ΔΤ. Δ371	ENHE	SIIT	TE 201	CIIM	REDIAN	ID M	D 21502
505	Sta		31. Date filed (Month, Day, Ye.	ar)	32. Regist	trar's Signa	ture	Ke J	ل ۱۳۸۷ سند.	وتدنيد	<u> </u>	<u> </u>	COM	ARVEVIA.	ا <u>تا و 11 ا</u>	0 41304
R	legistr	ar	APR 2 6	2006	PARE PRO	200	1									

		1 - For Stata Registrar 1. Decedent's Name (First, Middle		of Maryla	and / Depa	artmen rtificat			and M		eg. No.	006	3 73
Physic		MAMA	, 2401/	GOLIJI	KAYE					Month APRIL	Day	2006°	7:45 A M
/Medi Exami		4a. Facility Name (If not institution, 3500 CHEVERLY A					Town, or	Location o	f Death			ounty of Death	
Funeral Director		214-71-9163	6. Sex 1 □ M 2 🖾 F	7. Age (In y	rs. last birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day JAN 20	Year)	9. Birtt Cot 5 LIBI	nplace (State or Foreign untry) ERIA, WA
the Maryland 28a-f show	Director		E GEORGE'		City, Town or Lo	LY							10d. Inside City Limits 1 X Yes 2 □ No
uth with the 23a or 2	i Dire	10e. Street and Number 3500 CHEVERLY	AVENUE			10f. Zip	Code			1		en of What Co	
ours after des	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed F	2 X]No ive			dent of Hi	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto l	ecity Yes or No- Rican, etc.)	14	BERIA, Bace - Amer Black, White pecify: BL	rican Indian, e, etc.
	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	t grade completed,) (1-4or 5+)		kind of wo DO NOT u	rk done d se retired	ition luring most)	of workii	ng	16b. Kind	of Business/l	ndustry
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then any injury or other traumatic event, the Magneta.	o Be Co	17. Father's Name (First, Middle, L KLEMEE GOLIJ	,		. Н	<u>OMEMA</u>		18. Mothe		(First, Middle,	Maiden S	PRIVAT umame)	`E
and 2 should ealth and Men m 27 is marke	-	19a. Informant's Name/Relationsh					(Street a	and Numbe	r or Rura	I Route Number			ip Code) 20785
Pages 1 a nent of He ant: If item ary or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		JIAIN	. Place of Dispo cemetery, crei			1				ation - City or I	
permit. Depurtrimporte any nji		21. Signature of Fungal Serv				. Name an	d Addres	s of Facility	у J.	B. JENE	KINS	FUNERA	L HOME
Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. CAR Due to LU	each line. DIORES (or as a cons	PIRATOR equence of): ASTASIS				cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
icate be executed physicien and s the burial-transit	dical Examin	Cause (Disease of Injury that initiated events resulting in death) Last	Due to	ERVICAI (or as a cons YPERTEI									
ath certifi ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		binth 2 ☐ Fi nant at time o	etal death 3	Ectopic pr					23	d. Date of deli	very Day Year
w requires thet the de been signed by the e should be detached f	by	Part II. Other significant condition ANEMIA	ns contributing to o	death but not r	esulting in the u	nderlying c	ause give	on in Part I.			bacco use		the cause of death?
i: The law r icate has be r, paga 2 sh	Completed									24a. Was a autops perform	ned?	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of 21 No
Attanding Physicien: Th ir death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date (Mor	Inpatient 2 of Injury oth, Day Year)	ER/Outpatier 28b. Time of		8c. Injury Work	er. 4 □ Nur	rsing Hon	Check only on ne 5 E Reside 28d. Describe ho	ence 6[ify)
To the Hospital or Attandi Mithin 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Plac	e of Injury - Al ling, etc. (Spe	t home, farm, str cify)	eet, factory	r, office		2	28f. Location (SI City or Town	treet and in, State)	Number or Ru	ral Route Number,
To the Hospital or At Mithin 24 hours effer of To the Funeral Direct completely filled in by	ledical	(Check only 2 ☐ Medical E	Physician: To the teaminer: On the teaminer and man	e best of my le pasis of exami oner stated.	nowledge, death ination and/or in	vestigation	, in my op	pinion, deat	d place, a	ed at the time, d	ate and p	lace, and due	to the cause(s)
2 12 8	×	29b. Signature and title of certifier	and	uc	MD	290	License	172	50	1		signed (Month	
Pair		30. Name and address of person v	who completed cau		tem 23a) (Type,					IARYI.AND		785	
St Regist	ate	31. Date filed (Month, Day, Year) APR 1 2 2006	32.1	Registrar's Sig	nature	I NOP	<u> </u>		,				

		ľ	State of Maryland / Department of Health a 1- For Registrar Certificate of Death	•		06								
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of D Month	eath	Year	3. Time of Death							
1	/Medic	al				ounty of Death	2-30 M							
	Examin	ier	Anne Arundel Medical Center Annapolis	Dou		Anne Ar	undel							
4	Funeral Director		5. Social Security Number 6. Sex 19-36-7171 6. Sex 2DF 64 7rs. Security Number 2DF 64 8 15 15 15 16 16 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18	Min. 8. Date of 8 (Month, L	irth Day, Year) 27,19	9. Birtho Coul 41 Mar	place (State or Foreign htty) yland							
	and wo		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits							
	Mary B-f sh	tor	MD Anne Arundel Annapolis			1 ☐ Yes 2 XXX Vo								
	with the	Dire	10e. Street and Number 10f. Zip Code 2900 Shipmaster Way, #119 21401		10g. Citize	on of What Coul	ntry?							
	ns 23e	erai	2900 Shipmaster Way, #119 21401 11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces? 13. Was Decedent of Hispanic Original Process of Process	in? (Specify Yes or N	lo- 14	. Race - Americ								
920	urs after o	by Funeral Director		Puérto Rican, etc.)		Black, White,	^{etc.} Black							
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other treumatic event, its Medical Exercitational Exercitation	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	of working		of Business/In	dustry							
121	filed withi Hygiene. other than ent, It e M			's Name (First, Midd		xxon								
lanc	ld be fi ental H kad ot ic ever	To Be		Geneva Bro		umamey								
ary	2 should be and Mental is marked communicated	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	r or Rural Route Num	ber, City or	Town, State, Zip	Code)							
	and 2 lealth m 27 i		Beverly Gould (Wife) 2900 Shipmaster Way	, #119, Ar		is, MD								
nor	Pages 1		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Vet. Cem.	4-18-2006										
Baltimore,	그 돈 본 글 .		21. Signature of Funeral Service digensee 22. Name and Address of Facility	,		IIO VIIIC	, 110							
ä	Department of the services once		Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401											
· **	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Meta State Car Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, linter Onse International Car Part 2 (1997).											
3760,	ate be executed wysician and he burial-transit	icai Examiner	d											
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23	d. Date of delive	ery Day Year							
	uires that n signed b	þ	Part II. Other significant contained so continuous contained in the uniterity in the uniter		tobacco us	2	he cause of death?							
Reco	sicien: The law rec certificate has bee irector, page 2 shot	Completed	hart failure acute on chroni Ren	per	prior to completion of cause of death?									
ita	ysicien: The l is certiticate ha director, page	Be Co	25 as case referred to medical 26 Place	of Death (Check only		1 🗆 Yes	2 NO							
)t <	hysic this ce at direc	2	2 1 Yes 2 No Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Cther: 4 Nur	sing Home 5 Re			y)							
ouo	ding F	tion	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 2 Accident investigation 28a. Date of Injury 1 Month, Day Year) 28b. Time of Injury 4 Work? 1 Yes 2 N	28d. Describ	e now injury	occurred								
Division of Vital Records,	I or Attendii after death. Director: A I in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and own, State)	Number or Run	al Route Number,							
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely tilled in by the funeral	Medical C		d place, and due to the h occurred at the time	e cause(s) a e, date and p	nd manner as s lace, and due t	tated. o the cause(s)							
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number	11 (2 C	29d. Date	signed (Month,	Day, Year)							
			gencin y or en am 10 2	1438	M	rue 1	0, 2006							
			30. Name and address of person who confidence death (Item 23a) (Type, Print) MICHAEL J. Cal ENTA way 447 Defense High	way AN	NAPU	JMnz	144							
	Sta Regista													

			For State Registrar	State o	f Marylan		irtment of Healt tificate of Dea			ene g. Ño.)6	1317	15		
			1. Decedent's Name (First, Middle, La			2. Date of Death Month				3. Time of Death					
H	Physici: /Medic		PEGGY MARIE	CORI	NISH (GOLDEN		April			4:00	P ^M			
	Examin		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, Town, or Locat	ion of Death			ity of Death				
			8329 Governor B			to a filate to N	Ellicott	der 24 Hrs.	O. Data of Righ	How		I (Ot-1	C		
	Funeral		5. Social Security Number 6. S	9X □M 2 0 X F	7. Age (In yrs.	Yrs.	Months Days Hou	rs Min.	8. Date of Birth (Month, Day, 11-01-19	Year)	Cour	lace (State or itry) 71and	r-oreign		
	Director		216-38-7802 Usual Residence of Decedent		65				11-01-15	40	Hall	/Land			
	/fand		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside Cit			
	Mar-fst	tor	Maryland Howard			Ellicot	t					1 🗌 Yes	2 X No		
	or 28	Directo	10e. Street and Number				10f. Zip Code		10	og. Citizen o	of What Cour	ntry?			
	ath w	rai	8329 Governor Te	2104		US									
	tiled within 72 hours after death with the Maryland Hygiene. other then "natural; or Items 23a or 28a-f show ent, the Mscical Exercise minut be notified at	Funeral	11. Marital Status	Armed F	edent Ever in U	.S. 13. \	Was Decedent of Hispanic f Yes, specify Cuban, Med	corigin? (Spe kican, Puerto	Rican, etc.)		ace - Americ lack, White,				
36	rs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Gi Year or D	Ve		I□Yes 2MVNo <i>Spe</i>	city:		Spec	Blac	r le			
P	2 hou	ed	15. Decedent's E	lucation		16a. Dece	lent's Usual Occupation			16b. Kind of	Business/In-				
215	hin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (life.	kind of work done during DO NOT use retired)	most of worki	ng						
2	od with	Son		9		Pro		College		Loyo1		llege_			
ם	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last						(First, Middle, A						
<u>Y</u>	ould Men narke	ို	James Edward	Corni	sh	405 14-15	Es ng Address (Street and No	ther	Marie			Codal			
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (29 Governor								
ص ص	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Engirthmen must be rediffied at ance.		Rev.Wilbert Gol		20b. I	Place of Dispo	sition (Name of				n - City or To				
no	ages int of t: If it		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		State	•	natory or other place)	06/1	7/2006	'ambri	doo M	arvlana	1		
Baltimore,	artme ortan injur		21. Signature of Funeral Service Lice	-	Q		Cemetery . Name and Address of F				ure e in	aryran	4		
ä	Per Imp any		21. Signature of Fulleyal Sovice, Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 524 Race Street, Cambridge, Maryland 21613												
			23a. Part 1. Briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval												
PI	Physician		Immediate Cause (Final disease or condition		Istric	carc	inoma					Onset and D			
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):									
	CXammer	L	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consec										
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	DD9 (0	(or as a consec										
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec			-							
8760,	icate be executed physician and s the burial-transit	dical													
9	ificat g phy as the	ledi			95		11-1-2			1		-	1117		
Вох	th cer endin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	Ectopic pregnancy			23d. Date of delivery Month Day Yea			'ear					
Э. В	e deal he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Preg 9☐Unki	nant at time of one	death 5	Other (specify)			Wild Hart	ou, ···				
P.O.	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Phy	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying cause given in F	Part I.	23e. Did tob	acco use co	ontribute to t	he cause of de	eath?		
	signe d be d	d by	Hupertension	hyperc	0	emler			1 □ Ye	s 2 540	3 ☐ Prot	ably 4 🗆 U	Inknown		
Ö	w require been si should b	Completed by	,	11/100			VVVV		24a. Was a	n 241	b. Were auto	autopsy findings available			
Rec	The lav	E D							autops perform	y ned?	prior to co death?	mpletion of ca	ause of		
a		e Co	25. Was case referred to medical				26.1	Place of Deatl	1 Yes 2	No No	1 🗆 Yes	2 NO			
Ē	ysicien: Is certific director,	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1	Inpatient 2	ER/Outpatie	Other		me 5 Reside		Other (Specif	(y)			
1 0	Attending Physicien: r death. ector: After this certific: by the funeral director,		27. Manner of Death	28a. Date		28b. Time o	f 28c. Injury at Work?		28d. Describe ho	w injury occ	curred				
io	ttending lage the ctor: After the funer	atio	1 Natural 5 Pending 2 Accident investigation	n i	,,	,,	M 1 ☐ Yes	2 🗆 No							
Division of Vital Records,	l or Attence after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	280. Plac	e of Injury - At h	nome, farm, st ify)	eet, factory, office			tion (Street and Number or Rural Route Number, or Town, State)					
	Hospital or 14 hours afte Funeral Dir tely filled in			<u> </u>								4444			
	e Hospital 24 hours a e Funeral l letely filled	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the	ne best of my kn basis of examin nner stated.	owiedge, deat ation and/or in	h occurred at the time, da vestigation, in my opinion	te and place, , death occuri	ed at the time, d	ause(s) and ate and plac	e, and due t	o the cause(s)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Mec	29b. Signature and Mile of certifier	und ma	Juliou		29c. License num	ber	2	Day, Year)					
	⊢ < ⊢ ō		· 1//				D5390	08			12,2				
•			30. Name and address of person who	completed car	use of death (Ite	m 23a) (Type,	Print)						4		
_			Ellie Goldbioom	MO	21 Cr	ossina	ds Drive Ju	114 #41	DO OWIN	195 N	11115,	Maryl	and		
		ate	31. Date filed (Month, Day, Year) APR 13 200	6	Registrar's Sign	ature	illa.					21117			
	Regist	Idi	Let 24 4.0 500		100	0									

Please Type or Print in Plack Indelibled 1/2 Language All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APR Deer Veer **Physician** CHARL MRICKSON 2228 M 00 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 01/21/1930 Birthplace (State or Foreign Country)
 VA **Funeral** Months Days Hours Min 76 Yrs. Director 087-24-6121 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No VA Prince William Woodbridge Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22191 USA 15019 Illinois Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Item any Injury or other traumatic event, the Market 1 Never Married 2 Married 1□Yes 💥 No Baltimore, Maryland 21215-0036 Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hazel Buck Charles Valentine Hendrickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2217 Shore Drive, Edgewater, Md. 21037 Kathleen Raley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2006 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Quantico Natl. Cemetery 4/14/2082 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Roberter de McCollon 22. Name and Address of Facility Mountcastle Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, VA shock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mouth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by irector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 20 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA neral Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) enl 021438 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY, ANNAPOLD arenta un 445 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 919 AM ERICA 100b 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bretimors N/A Medical 5 Marylan If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 220-41-2971 11 Yrs. Director 1994 July Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f show traumatic svant, it a Maxical Examinar must be notilled at Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330 Highland Dr. Apt. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 ☐ Yes 2 XNo ff Yes, Give Year or Dates: 1XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th Student School School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finand Mental Fisher and Mental Fisher States of the states Leonard K. Hall Sarah Downey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum once. Leonard K. Hall(Father) 330 Highland Dr. Apt. T3 Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4-12-06 Glen Haven Glen Burnie, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williame Redesse Facilitisons Mortuary, P.A. Lavy B. Teere 821 West St. Annapolis, Md. 21401 mod 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, flany loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the fF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by peq 2. No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2. No Attanding Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the f Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) death (ftem 23a) (Type, Print) South Greens 31. Date filed (Month, Day, Year) Registrar's Signature State APR 11 2006 Registrar

			For State Registrer	State of Maryland		artmen				F	leg. No.	06	131	78		
ı	Physicia	an	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time of			
	/Medic	Morton Israel Ho 4a. Facility Name (If not institution, give s		4h Cihi	Tournor	Location of		Apr.		006	1:15	рМ				
1	Examin	er	949 Mastline Dri		, ,	poli		Deam		4c. County of Death Anne Arundel						
	Funeral Director		5. Social Security Number 6. Sex		ast birthday) Yrs.	If Under Months	-	If Under 2 Hours	Min.	, 1925	9. Birthplace (State or Foreign					
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City	. Town or Lo	cation						1	0d. Inside Cit	v Limits		
	Maryli f eho	tor	Maryland Anne Ar	undel Ani	napoli	s							1XXYes	2 🗆 No		
Maryland 21215-0036	with the	Director	10e. Street and Number 10f. Zip Code 949 Mastline Drive 21401								10g. Citizen of What Country? United States					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "natural", or Items 23a or 28a-f ehow appringury or other traumatic event, the Medical Examinating the notified at angle.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1.XXYes 2 □ No If Yes, Give WW I Year or Dates:	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R				- American Indian, White, etc. White				
	in 72 hou n natura dedical E	Completed	15. Decedent's Educ (Specify only highest grade		(Give	 Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business/Industry				
212	giene giene er the	Com		5+	Polic	y Pla					U.S. G					
land	uld be file Mental Hy irked oth	To Be	17. Father's Name (First, Middle, Last) Abraham Horvitz 18. Mother's Name Eva Sche								me (First, Middle, Maiden Surname)					
Man	and 2 sho alth and 127 le mu er trauma		19a. Informant's Name/Relationship (Ty) Halina Horvitz/Wi			-				Route Numbe	-		Code)			
Baltimore,	Pages 1 aent of He nt: If Item ry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	ace of Dispo emetery, crei Veter	matory or o	ther place			0,2006	20c. Location					
Balti	permit. I Depertm Importar any injui		21. Signature of Funeral Service License			2. Name an	d Addres	s of Facility	Har	desty I Annapo	Tuneral	Home	, P.A.	01		
F	Physician /Medical												ween			
	Examiner	iner	Sequentially list conditions, if any, leading to immediate causal. Entar Underlying Cause (Disease or injury													
,092	ate be executed hysicien end the burial-transit	if any, leading to immediate cause. Entar Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d.														
89	rtificat ng phy as th		IF FEMALE:													
.O. Box	es thet the death certifica igned by the attending ph be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown				23d. Date of delivery Month Day Year									
<u>α</u>	.≘ v ⊤o	至	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the car 1 Yes 2 No 3 Probably					
Vital Records,	The law requiete has been page 2 should	Completed								24a. Was autop perfor 1 Yes	an 24b sy rmed? 2 No	. Were auto prior to co death? 1 Yes	ppsy lindings ampletion of ca	available ause ol		
/ita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Cthe			(Check only o						
o	Phys	lon: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 2	28c. Injury Work	at ?		8d. Describe h	lence 6 0		(y)			
Division	to the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, larm, streel, lactory, office building, etc. (Specify)						8l. Location (S City or Tow	Street and Nun m, State)	nber or Rura	al Route Num	ber,		
_	Hospital 4 hours Funeral tely filled	ledical Ce	29a. Certifier Contifying Physics (Check only one)	sician: To the best of my kno- ner: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tim	e, date and pinion, deat	d place, a	nd due to the old at the time,	cause(s) and r date and place	nanner as s e, and due t	stated. the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/ 410		290	c. License	number	16	7	29d. Date sign	ned (Month,	Day, Year)			
			30. Name and address of person who co	mpleted cause of death (Item	1 23а) (Туре,	Print)	<u>د ب</u>	ار	10		7.1	116	(
	Sta Regist		31. Date filed (Month, Day, Year) APR 11 20	32 Registrar's Signa		and l	11.	und	•	Plea	1 cca	1	en te	r		

	• •		For Amend Item #5 State of Maryland / Dep State RegistrarWCHD/SH 4/21/06 per FH Ce	artment of Health and Mertificate of Death		eñe() () ()	3179							
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Frederick Woodrow Hose Sr.		2. Date of Death Month APRIL	Day 2006	3. Time of Death							
*	Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown,		4c. County of Death Washington								
3	Funeral Director		5. Social Security Number 218-34-3829 1 \(\)	Months Days Hours Min.	8. Date of Birth (Month, Day,) Jan. 16,		hplace (State or Foreign nuntry) airsValley							
	anyland show	_	10a. State 10b. County 10c. City, Town or L	ocation Spring			10d. Inside City Limits 1 ☐ Yes 2 ☑ No							
Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland	the M	recto	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	••							
	ath with	ralD	13214 Draper Road	21722		U.S.A								
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show miportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Maclical Examination and Item notified at any injury or other traumatic event, Ite Maclical Examination and Item notified at any injury or other traumatic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.							
	I within 72 h jene. r than "natu ing Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade 16a. Dec (Giv life.)	6b. Kind of Business/Industry Electric Co.										
	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Walter Lee Hose		Pearl R	,								
	and 2 sho ealth and i n 27 is me			ling Address (Street and Number or Rura 214 Draper Road										
Baltimore,	Pages 1 a ment of Hea ant: If item ury or othe		4 Donation 5 Other (Specify) Blairs	valley Cem Apr	06	oc. Location - City or Llear Spr	ing,MD							
Bait	permit. Departi Import sny inj once.		21. Signature of Fugeral Service-Lightnee	22. Name and Address of Facility Donald Edwin Tho P.O.Box 310 Clea	mpson F r Sprin	uneral H	lome,Inc 722							
	Physician		23a. Pant. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death											
-A	/Medical Examiner		Due to (or as a consequence of):											
****	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
8760,	ate be executed hysicien and the burial-transit	Icai	resulting in death) Last Due to of s a consequence of): d. He post cellul	er concurrono										
P.O. Box 6	that the death certifica hed by the attending ph detached for use as ti	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year							
	uires that signed b	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			o the cause of death?							
Records,	Physician: The law requires that the this certificate has been signed by the tall director, page 2 should be delached.	Completed	englissed sinces, Jasur	et, fortel	24a. Was an autopsy performe	prior to death?	itopsy findings available completion of cause of							
of Vital	cian:] ertifical ector, p	Be	25. Was case referred to medical examiner		1 Yes 2	LINO ILITES	20,40							
on of \	of end	tion: To	1 Yes 2 No Hospital: 1 I patient 2 ER/Outpatient 2. Texto Pending (Month, Day Year) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time Injury (Month, Day Year)	of 28c. Injury at	g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred									
Division	If or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office										
	To the Hospital within 24 hours a To the Funeral completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cau red at the lime, dat	ise(s) and manner as e and place, and due	s stated. to the cause(s)							
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	290	29d. Date signed (Month, Day, Year) 4/14/06								
			30. Name and address of person who completed cause of death (Item 23a) (Type	D62440		7/17/	OP							
31	4-15		Jaroslaw Kalka, MD 251 E. Antiet	am St., Hagerstown	, MD 21	1740								
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hade										

			1 = For State Registrar	State of	Marylan			nt of H				Reg. No.	006	13180		
	Physici	an	Decedent's Name (First, Middle							i	2. Date of Dea Month	Day	Year	3. Time of Death		
	/Medic		Fauline	Α.		Hahn					April_	9	2006	10:15 A M	_	
	Examin	er	4a. Fecility Name (If not institution				4b. City,	Town, or	Location o	f Death			County of Death	1		
			7277 Augustine 5. Social Security Number		. Age (In yrs.	la et hirthday)		rget r1 Year	OWN If Under 2	24 Hrs	9 Date of Birt		Cecil	colone (State or Coming	_	
	Funeral Director		001-24-1123 Usual Residence of Decedent	1□M 2ÅF	7 Age (iii yis.		Months		Hours	Min.	8. Date of Birt (Month, Da April 2	v. Year)	9. Birti	nplace (State or Foreign untry) MA	_	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	_	
	Many Many	ţō	MD Cec	il	G	eorget	ดเมท							1 ☐ Yes 2 X No		
	r 288	Funeral Director	10e. Street and Number					Code				10g. Citiz	en of What Cou	untry?	_	
	h wit	a D	7277 Augustin	e Herman H	wu.		21	930				USA				
	deal	ner	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.			spanic Orig	gin? (Spec	offy Yes or No-		4. Race - Amer Black, White		_	
ထ္ထ	or It	E/	1 ☐ Never Married 2 ☐ Marri		No No		1 🗀 Yes		Specify:	,			Specify:	, 610.		
8	ural',	d by	3 Widowed 4 □ Divorced	Year or Dat	es:								Wha		_	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f show fra Medical Exactinat must be notified at	Completed	15. Decedent (Specify onfy highes	's Education t grade completed)		16a. Deced	kind of wo	al Occupa ork done di ise retired)	u <i>ri</i> na most	of workin	g	16b. Kin	d of Business/l	ndustry		
2	within	m	Elementary/Secondary (0-12)	College (1-	tor 5+)			onisi				В	Beach Resorts			
0 0	be filed ital Hygi of other event, I	Ö	17. Father's Name (First, Middle, I	Last)						r's Name	(First, Middle,				-	
an	ld be ental ked c	To Be	Stanley L. Sm	ith					Dut	h I	Bacon					
Maryland	should nd Men marke	-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address	s (Street a				er, City or	Town, State, Z	ip Code)	_	
ž	and 2 ealth a n 27 ls		Stephen M. Asl	hbu/son		P. (n. Ro	x 3	Geon	actou	on, MD	2103	n			
ē,	s 1 a of Hei item othe		20a. Method of Disposition			Place of Dispo	sition (Na.	me of		Da	ate	20c. Loc	ation - City or 1	Town, State	_	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show amportant: If item 27 is marked other than "natural", or Itama 1 and 1 a		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (Sp		ale				1	4-13	3-2006	Chos	anaaha	Citu. MD		
ä	permit. Departmitimporta Importa sny inju		21. Signature of Funeral Service	ensee		22	. Name a	nd Addres	s of Facility	R.T.	Foara	l Fun	eral Ho	me, P.A.		
m	Depa Impo sny ir		, und	7		3	18 Ge	orge	Stre	et, (Chesape	ake	City, N	ID 21915		
			27a. art1. Enter the disease, or shock, or heart failure. List	complications that cal	used the deat									Approximate Interval Between		
100	Physician		immediate Cause (Final disease or contition resulting in Jeath) a. The tactata we not continue to the conti										Onset and Death			
	/Medical Examiner		resulting in (eath) Due to (or as a consequence of):											_		
	Examiner		Septentially list conditions, if any, leading to immediate cause (Disease or injury) b. Due to (or as a consequence of):													
	sit ed	Examiner														
_	and and Il-tran	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):										_			
3760,	death certificate be executed e attending physician and nd for use as the burial-transit	calE				,										
687	ficate p phys s the			d							· · · · · · · · · · · · · · · · · · ·				_	
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								2	3d. Date of deliv	/ery			
m.	0 0 0	cia	in the past 12 menths? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)								Month Day Year					
o.	t the by the	hys	9 Unknown	9□ Unknov	'n											
S, D	The law requires that the death ste has been signed by the atte bage 2 should be detached for	by Physician/Med	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did to	bacco us	se contribute to	the cause of death?		
D.C	w requir been si should	ted									1 🗆 Y	res 2	No 3∏Pro	bably 4 Unknown		
Vital Record	has be	Completed									24a. Was autop		24b. Were aut	opsy findings available ompletion of cause of		
<u> </u>	The ate h page	Con									perfo	med?	death? 1 ☐ Yes			
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Ma aminali						of Death	(Check only o	ne)			_	
o	Phyaician: this certificanal director,	ပို	1 Yes 2 No	Hospital: 1 🗆 Inj		ER/Outpatien		-	4 🔲 IVUI	-	-		Other (Spec	ify)	_	
	ing l	io	27. Manner of D ath 1 ☑ Natural 5 ☐ Pending		Day Yeer)	28b. Time of Injury	м	28c. Injury Work	aτ ? ′es 2 ⊡ N		8d. Describe h	iow injury	occurred			
<u>S</u>	Attending r death. ector: After by the funer	lica	Accident investig	ot be	f Injury - At ho	ome, farm, str			00 201		8f. Location (5	Street and	Number or Rus	ral Route Number,	-	
Division	s after al Director	Certification:	4 Homicide determi	building	, etc. (Specif	y)	001, 120101	y, omoo			City or Tow					
	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funarel Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying (Check only one)	g Physician: To the b Examiner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred vestigation	at the time , in my op	e, date and inion, deat	d place, ar h occurred	nd due to the o	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)		
	To the within 3	Me	29b. Signature and title of certifier	1	101	7	29	c. License	number			29d. Date	signed (Month	, Dey, Year)	_	
)			Store	tel	elme	1 3		Do	64	14	16	41	11/0.	6		
	2		30. Name and address of person	who completed cause	/			1 -	7	/1	100	-/-		C1 1 2	_	
)		Steven (· talco		145	10.	10 2	00,7	011	7 0	7/07	ewn-	Steriter Rd		
	Sta Registr	A .	APR 1 2 2006	Regue 32. Reg	gistrar's Signa	porte	,		, •	- 000	and the	_	1174	3		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Year April 10, **Physician** David Hyle Albert 7:26 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7928 Naas Road Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/17/1953 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 18 M 2□ F 222-36-2901 53 Director Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 7928 Naas Road USA r death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☑ Yes 2 □ No If Yes, Give Army Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled none it of Health and Mental Hygie If Item 27 te marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda E. Bales Grayson William Hyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7928 Naas Rd., Salisbury, MD 21801 Debbie Hyle/wife Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Maryland veterans 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4/14/06 Hurlock, MD * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association Kell Ol Kleus 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNELMONIA **Physician** 1 WOOK /Medical Due to (or as a consequence of): 2001 Examiner SEVENE MALNUTRITION CACHOXIA WI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 1 ANGREATI Hospital or Attending Physician: The law requires that the death certificate be executed REMPRENT attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical NIA IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? þ WELMOIN CITI WITHRENIA 2 🗆 No 3 Probably 4 ☐Unknown Completed SYNDRONE 24b. Were autopsy findings available prior to completion of cause of death? HRO NIC 24a. Was an certificate has autopsy performed2 Yes 2 No N. A corn MONERATE 1 Yes 1 Yes 2 No Be 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury N.A ☑Natural 5 Pending N.A investigation 1 TYes N.A. 2 Accident Director: 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours at To the Funeral D completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 112/06 10058662 OUT PATIENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 ENCARNITA SANTUS- TECSON M.n. 31. Date liled (Month, Day, Year) APR 12 32. Registrar's Signature State 2006 Registrar

	1	For State Registrar		State of	of Marylai		artment rtificate					giene	16	13182
		Decedent's Name (First,	Middle, Last)								. Date of Dea		Year	3. Time of Death
Physician /Medical		Ina	Ма	е	H	igson				Aı	or 18, 2			11:50 pm⁴
Examiner		Frostburg Vill					Frost	burg	_			Allega		
Funeral Director		5. Social Security Number 212-18-1999		M 2√2 F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	Date of Birt (Month, Date Viay 17	, 1921_	9. Birth	place (State or Foreign intry)
aryland show	-	Usual Residence of Deceder 10a. State 10b. C			10c. C	ity, Town or Lo		1						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the Me	-	10e. Street and Number	liegally			Odinib	10f. Zip					10g. Citizen of	What Cou	
h with	2	607 White Av	enue/					2	1502			US	SA	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itema 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at To Do Completed by Entrered Director	Dy ruilei	11. Marital Status 1 ☐ Never Married 2 ☐ 3 🕱 Widowed 4 ☐ Div] Married	Armed F	iveX No		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexical Specify:		fy Yes or No- ican, etc.)	BI	ace - Amer ack, White ^{ify:} whit	
21215-0036 ed within 72 hours af ygiene af per then "natural, or it, the Medical Exemi		(Specify only Elementary/Secondary (C		ompleted,) (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d	<i>luring</i> mos	st of working		16b. Kind of	Business/li	ndustry
nd 21 be filed wi tal Hygien d other th		12 17. Father's Name (First, M				Clerk				,	First, Middle.	First Na	ime)	Dank
Yla pould I I Men I Men	2	Calvin H. L				10h Maili	- Addroon	/Ctmat /				ow Larg		in Code)
ore, Maryland ss 1 and 2 should be file st 1 and 2 should be file st Health and Mental by tiem 27 Is marked oth other traumatic event		Thomas Higs		рө, Print) SC		607	White	Ave			Cumb	erland		MD 21502
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot		lemoval from	State	Place of Dispo cemetery, cre iset Mem	matory or o	ther plac	θ)	Da 4/2	21/2006	Cumbe		
Balti permit. Departr Imports any inju		21. Signature of Fuheral S	DWD =	f Ac	ando	14	108	Virgi	nia Av	enue: (ie, P.A. Cumberl	and, MD	21502	
Physician cate be executed by sicien and physicien and the private that th	dical Examiner	23a. Part 1. Enter the dises shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ſ	Due to	o (or as a conse	equence of):							ā	Onset and Death
I Records, P.O. Box 68760, < The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 ☐ Yes 2 □ No 9 □ Unknown	ant	1 Live	utcome of preg birth 2 ☐ Fe gnant at time of nown	tal death 3	⊒Ectopic pi ⊒ Other (sp						Date of deli	very Day Year
ds, P.O.	d by Pn	Part II. Other significant c		_	death but not re		underlying o	~	en in Part			obacco use co Yes 2 □ No		the cause of death?
Record The law require ate has been signage 2 should the	Completed	PNEU	NTIA	,							24a. Was auto perfo 1 Yes		prior to death?	topsy findings available completion of cause of
/ita	ne C	25. Was case referred to reaminer?	-	1				100		e of Death	(Check only	оле)		
Of Physics of this of all directions of the control	Certification: 10	2 ☐ Accident	Pending investigation	28a. Dat (Mo	Inpatient 2 e of Injury onth, Day Year)	ER/Outpatie 28b. Time Injury		28c. Injur Wor	v at]No	8d. Describe	dence 6 C	urred	
Divis	Certific		Could not be determined	288. Pla	ce of Injury - At Iding, etc. (Spe	home, farm, s cify)	treet, factor	y, office		2	8f. Location (City or To		mber or Ru	iral Route Number,
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical			ner: On the	he best of my k basis of exami unner stated.									stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of	-				29	c. Licens	e number			29d. Date sig		
1			T	Gedhi			E	D2	6907	7		APRIL	20,	2006
6		30. Name and address of	person who c	ompleted ca	use of death (I	tem 23a) (Type	, Print)	۱۸/۵۱	ch Pa	nad Ci	ımberl	and MC	2150)2
Stat Registra	2 3	31 Harjit Sidhu, AF	M ₀ D. PR 2 6	2006	Recistrar's Sig	mature B	Lossel.	v val	311 1 \	Juu O				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** $1^{1}4^{4}$, 2006April 5:45 A M Helen Graham Hoshall /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Manor Care Potomac Potomac If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 31, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. 1917 Maryland 219-44-7721 88 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. Count and Mental Hygiene. Is marked other than "naturel", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Mt. Joy Lancaster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17552 USA 766 Ferndale Rd. Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydie Graham William Robert Wheeler 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 states to Department of Health ar Important: if Item 27 feen y injury or other trausonce. 766 Ferndale Rd., Mt. Joy, PA 17552 Terrence Hoshall 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory, or other place)
Vernon United
Methodist Cemetery 20, White Hall, MD April 2006 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuheral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Meda 17349 24 Second St., New Freedom, PA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ASTIRATION 3 NECHONIA resulting in death) /Medical Due to (or as a consequence of): Examiner DEMERT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of). nding physician and use es the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use es the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an certificete 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 TYes 2 No death. investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and tyle of certific 4-14-2006. 40051280

DHMH 17 Rev 1/2001

Registrar

3

31. Date filed (Month, Day, Year)

APR 2 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar DO

9715 Medical Center Dr., Rockville, MD 20850

32. Registrar's Signature

		Please Type or Pri	nt in Black In	delible Ink. Ensure A	II Copies A	re Legible.	
		1 = For State of M Registrar		artment of Health and Natificate of Death		ne 006 1	3184
Physic /Medi		Decedent's Name (First, Middle, Last) WILLARD ALLEN HAR	RIS, JR.		2. Date of Death Month April 14	Day Year 4, 2006	3. Time of Death 10:00A
Exami		4a. Fecility Name (If not institution, give street and number) Civista Medical Center 5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday)	4b. City, Town, or Location of Death La Plata If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Charles	ace (State or Foreign
Funeral Director		577-52-1457 X M 2 F Usual Residence of Decedent	73 Yrs.	Months Days Hours Min.	(Month, Day, Y	,1933 WASI	H.,DC
e Marylar 3a-f show	Director	10b. County MARYLAND CHARLES	10c. City, Town or Lo	PLATA		10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
If yield G / I / I S-UUSO should be filed within 72 hours after death with the Maryland ad Mental Hygiene. marked other than "neturel", or Iteme 23a or 28a-f show imatic event, Ital Mudical Evan. sermust be revitified at	Funeral Dire	7870 ESTEVEZ ROAD 11. Marital Status 1 □ Never Married 2 Marned 1. □ Yes 2 Marned	? No	10f. Zip Code 20646 Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A. 14. Race - America Black, White, e	ın Indian,
2-UUS 2 hours a seturel; o	b	3 Widowed 4 Divorced Year or Dates:	16a. Dece	1 ☐ Yes 2 ☒ ☒ o Specify: dent's Usual Occupation kind of work done during most of work	16	Specify: WH :	ITE ustry
d within 7 giene.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+) life. i	R/PRESIDENT FUR		CO. HARRI	S FURN.C
Maryland 21215-UU30 d 2 should be filed within 72 hours af th and Mental Hygiene. 7 le marked other than "neturel", or traumatic event, the Mudical Evan.	To Be	17. Father's Name (First, Middle, Last) WILLARD ALLEN HARRIS,	SR.		e (First, Middle, Ma AE NEWT)		
M 2 2 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1		19a. Informant's Name/Relationship (Type, Print) KATHLEEN HARRIS-SPOUSE 20a. Method of Disposition	787	ng Address (Street and Number or Rui O ESTEVEZ ROAD sition (Name of	, LA PLA		0646
Dallillore, permit. Pages 1 ac Department of Hea Important: If item: eny injury or other		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) ENTOMBM 21. Signature of Funeral Service Licensee	ENT TRINI	TAY MEM. GDNS. Name and Address of Facility RAYMOND FUNERA			MD
Physician /Medical		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	ino. vrdiae	LA PLATA, MARY	LAND 206	546	Approximate Interval Between Onset and Death
be executed purial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): Hill a consequence of): Layer a consequence of):	pulmona surgery	ond a	holi3m nostros	
attending for use a	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
quires that the duning the digned by the	d by Ph	Part II. Other significant conditions contributing to death t	out not resulting in the u	nderlying cause given in Part I.		cco use contribute to the	
lor Attending Physicien: The law requires that lee to the law requires the after death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be	Completed				24a. Was an autopsy performe	prior to com	sy findings available pletion of cause of
icien: Sertific ector,	Be	25. Was case referred to medical examiner?			h Check only one		
Physic this at dir	2	1 Yes 25 No Hospital: 1 Vipatii 27. Manner of Death 28a. Date of Inju				e 6 ☐Other (Specify)	
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investigation	ny Year) Injury	Work? M 1 Yes 2 No	28d. Describe how		0-4-4/
pital or A rurs after arel Direc		4 Homicide Solominis building, e	jury - At home, farm, str tc. (Specify)		City or Town, S		
To the Hospital within 24 hours To the Funerel completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Exeminer: On the basis of and manner st	of examination and/or in	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the caus	se(s) and manner as sta a and place, and due to t	ted. he cause(s)
To To To Com	2	29b. Signature and title of certifier		29c. License number D-19631		1. Date signed (Month, D 4 - 14-0	
10		30. Name and address of person who completed cause of a Suryakant J. Patel, MD 11	3/10 Pombro	oleo Caucho Che 11	3 Waldori	E. Marvland	20603
St Regist	ate frar	31. Date filed (Month, Day, Year) APR 2 6 2006 32. Regist	rar's Signature	edi.		-,a. j. rand	20003
DHMH 17 Rev 1/2	2001		-/				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2612 ane 8. Date of Birth Month, Day, Year) Dec 1, 1969 Under 1 Year Birthplace (State or Foreign Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F **W** Yrs. 220-78-8525 36 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28e-f ehov r then "naturel", or iteme 23a or 28e-f ehor the Medical Examiner must be notified at Cumberland MD Allegany 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 12612 Wilson Lane filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tri State Community 12 maintenance .. Pages 1 and 2 should be filed very the property of Health and Mental Hygie trant: If item 27 is marked other talury or other traumatic event, It. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lois R. Mallow Glavan Rovce A. Hedrick, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 13005 Milpoint Drive NE Cumberland MD 21502 Michelle Hedrick wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4/19/2006 MD Restlawn Memorial Gardens LaVale 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home, PA 21. Signatura of Furteral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final inshot Wound **Physician** disease or condition resulting in death) 40 minute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the all P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No certificate After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ Yes 1 Inpatient 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (M + th, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pendina 1 □ Yes 2 🕱 No inflicted Gunshot Wound death. 2006 investigation 2 Accident 1:00 Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Pla e of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 ☐ Homicide within 24 hours after To the Funeral Dire 12612 Wil Home pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

APR 2 6 2006

32. Registrar's Signature

			1 - For Stete Registrar	State of Mar		partment of H			giene (06	13186
			1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	th		3. Time of Death
	Physici /Medic		Sheila	Vonne	Hull			Month	Day	Year C 6	10:50 AM
	Examin		4a. Facility Name (If not institution,	1 11 1	L 1	- A	r Location of Death	1	4c. County		
			Sacred Her				erland			gan	
n	Funeral Director		5. Social Security Number 218-64-8313	5. Sex 7. Age (1	In yrs. last birthda) Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day Jun 20	1953	9. Birthpl Count	ace (State or Foreign
			Usual Residence of Decedent					3u11 20	, 1333	10	
	nylan how	_	10a. State 10b. County MD Alleq		Oc. City, Town or I					10	Od. Inside City Limits
	8a-1	Director		arry		aptown					1 X Yes 2 □ No
	with the	吉	10e. Street and Number	troot		10f. Zip Code	21502	1	l 10g. Citizen of	What Count SA	try?
	ns 23	eral	14913 Howard S	12. Was Decedent Eve	er in U.S. 13			pecify Yes or No-		ce - America	an Indian
က္	or Iter	Funeral I	1 ☐ Never Married 2 ☐ Married	Armed Forces?		. Was Decedent of H If Yes, specify Cuba		o Rican, etc.)		ck, White, e	etc.
9	ral, c	<u>ام</u>	3 Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 No	Specify:		Specif	white	Э
<u>7</u>	"natu	Completed	15. Decedent's (Specify only highest		(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	during most of wor	rking	16b. Kind of B	usiness/Ind	ustry
7	within	g L	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	"		own hor	me	
9	illed Hygi other	Be C	17. Father's Name (First, Middle, La	ist)	1101110	ITICINO	18. Mother's Nan	me (First, Middle,			
Maryland 21215-0036	should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. marked other than "natural", or liems 23a or 28a-1 show marked other than "natural", or liems 23a or 28a-1 show marked other than "natural".	ToB	James Perry E	3lank			Olga J	lohns Bla	nk		
ē	de E E		19a. Informant's Name/Relationship		19b. Mai	ling Address (Street	and Number or Ru	iral Route Number	r, City or Town,	State, Zip	Code)
≥,	s 1 and 2 should f Health and Mer Item 27 Is marke other treumatic		Nicholas Hull	son		Rear Fred	Jerick St.		erland		21502
altimore,	it of H if ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State		ematory or other plac	;e)	Date 4/24/2006	20c. Location		10.00
	it. Pa intmen intent: njury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie			morial Park	as of Essible		Cumbe	eriano	MD
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It eny Injury or other tre		1 /////	A L	1/11	22. Name and Addres Scarpel			land MD	04500	9
			23a. Part). Enter the disease, or co	emplications that caused th	e death. Do not er	108 VICE	ginia Avenu ig, such as cardiac	or respiratory arr	iana, MD est,		Approximate
	Physician		Immediate dause (Final	Recure	1	_					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a c		wian	Cance	<u> </u>			6 months
	Examiner		Sequentially list conditions	b							
	sit ad	Iner	Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):						
V	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):						
8760,	The law requires that the death certificate be executed ite has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical E									
687	ifficate g phy as the			U							
Вох	eath certific attending p for use as I	clan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [□Ectopic pregnancy				te of defiver	ry
. B	e deal	slcle	in the past 12 months? 1 Yes 2 No	4☐Pregnant at tim		Other (specify)			Мо	onth [Day Year
P.0	het the de d by the detached	by Physic	9 ☐ Unknown Part II, Other significant condition		tot reculting in the	underhing enves and	on in Donal	22a Did tal		براد مدم دم داد،	e cause of death?
Vital Records,	w requires thet been signed t should be det	d by	Tarrii, Ottor Significant contactori	Contributing to death but i	or resulting at the	undenying cause give	min rani.	23€. Did tol		3 ☐ Proba	.,
Sor	v requ been shoul	ete			· · · · · · · · · · · · · · · · · · ·			24a. Was a		-	
Ä	The tay ate has page 2	Completed						autops	ned?	death?	sy findings available apletion of cause of
		6)	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes :		1 ☐ Yes 2	2 X No
	Physicien: this certific al director.	To B	examiner? 1 ☐ Yes 2 █ No	Hospitaf: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Othe		lome 5 Reside		er (Specify))
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time	of 28c. fnjur		28d. Describe ho			
S	uttendir death. ctor: Al y the fu	catle	2 Accident investigat	tion		M 1	Yes 2 □No				
Division of	or Attending Physicien: ifter death. Director: After this certific. in by the funeral director.	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of fnjury building, etc. (At home, farm, s Specify) 	treet, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
_	pital ours e aral (1 1 1	29a. Certifier 1X Certifying	Physician: To the best of n	ny kaomindan dan	the accurred at the time	no data and plans				
	To the Hospital or Attendir within 24 hours effer death. To the Funeral Director: At completely filled in by the fu	Medical	one)	and manner stated	amination and/or i	nvestigation, in my of	pinion, death occur	irred at the time, d	ate and place,	and due to	the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	201		29c. License	a number	2	9d. Date signe	d (Month, D	Day, Year)
	-		29b. Signature and title of certifier Worksork 30. Name and address of person wh WONSORK SHI 31. Date filed (Month, Day, Year) APR 2 6 20	the MO		Doc	55325	-	April	20,	2006
	M		30. Name and address of person wh	o completed cause of deat	h (Item 23a) (Type	, Print)					
			WONSOCK SHI	N MD 487	Farn Te	trace	Frostbi	mag M	10215	32	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 20	06 Registrar's	Signature	de la		J			
	riegisti		0 = 0								

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legibl
--	------------------------------

		St	ate of Maryland / Depa	artment of Hea	ilth and Mental Hy	giene	0107
	•	For State Registrar	Cer	tificate of De		Reg. No. UUD	3101
Physic	an	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	Bath Day Year	3. Time of Death
/Medi	al	Rosa L. Harri 4a. Facility Name (If not institution, give street		4b. City, Town, or Loc		14, 2006 4c. County of Death	10:28A
Examir	er	Civista Medical Cen		La Plata	and or boat.	Charles	
Funeral	1 1	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. 8. Date of Bi lours Min. (Month, Da	rth 9. Birthpla	ice (State or Foreign y)
Director		577-38-7417 1 ¹	2XF 83 Yrs.	Wildright Says	Sept.	6,1922 SC	
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10	d. Inside City Limits
Mary Field	ţō	MD. Charles	LaPlata	a			1☆Yes 2□No
ith the or 28s	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Count	•
ath w	rail	206-A West Hawtho		2064		United Sta	
ter de	-une	A A	☐Yes 25 No		nic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.)	Black, White, e	
ours at	by	11	Yes, Give Year or Dates:	1 ☐ Yes 2 🔯 No S	pecify:	Specify: Bla	ck
72 hc	Completed	15. Decedent's Educatio (Specify only highest grade con	nnieted) (Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	16b. Kind of Business/Indi	ıstry
within sne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Domestic		Private	
LILU X I X 13-0030 be filed within 72 hours after death with the Maryland tal thygiene. d other then "natural", or Itema 23a or 28a-1 ehow event, the Medicul Exart art must be notified at	Be Co	17. Father's Name (First, Middle, Last)		18.	. Mother's Name (First, Middle	e, Maiden Sumame)	
2 should be and Mental is marked of aumatic even	To B	Jerod Glover				omas	
2 sho and I s ma		19a. Informant's Name/Relationship (Type, F			Number or Rural Route Numb		Code)
C, N 1 and 1 and Health em 27 thar t		Maggie Smith-Coon 20a. Method of Disposition	20b. Place of Dispo	sition (Name of	t Hawthorne	20c. Location - City or Tov	vn, State
DESILITIOTE, INSTITUTE A LATE 13-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23a or 28a-1 ehow appriant or other traumatic event, the Medical Example at must be notified at energy injury or other traumatic event, the Medical Example at most be notified at energy injury or other traumatic event, the Medical Example at most be notified at energy.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place)	Cem. 4/21/	06 Suitlan	d,MD.
Dallino permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licensee			Facility Hodges		
		Anne Ed			r Hill Rd.,		
		23a. Part1. Enter the disease, or complication anock, or heart failure. List only one car	ause on each line.				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ANEURISM D Due to (or as a consequence of):	F BRACITE	CEPIXALIC	78-122cg	
Examiner		f.	HVPZRTPZNL	New			
/ 7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequence of):				
	calE		Duo to (or as a concequence or).			de-that was	*
ob/ ifficate g phys as the	-	d					
hat the death certificated by the attending phicagon detached for use as the	Physician/Med	23b. was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3[Ectopic pregnancy		23d. Date of deliver Month	y Day Year
the dea by the at	sici		4□Pregnant at time of death 5[9□Unknown	Other (specify)			
that the ed by detac		Part II. Other significant conditions contribu	uting to death but not resulting in the u	ınderiying cause given i	n Part I. 23e. Did	tobacco use contribute to th	e cause of death?
	ed by	DIABBIES	MERITUS		1 [Yes 2. No 3. Proba	abiy 4 □Unknown
S & G	Completed				24a. Wa	s an 24b. Were autop	sy lindings available apletion of cause of
_ = # d	Com				рег	formed? death?	2 ½ No
VITAI Ilcian: 1 certifical rector, p	Be	25. Was case referred to medical examiner?	wtat:		6. Place of Death (Check only		
		1 Yes 2 No	I Inpatient 2 M2 Envoutpatie		4 Nursing Home 5 Re	sidence 6 ∐Other (Specify how injury occurred)
Phys this	1: To	27. Manner of Death 2	Sa. Date of fillury 200. Tille C				
Phys this	11-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury (Month, Day Year)	Work?	s 2 No		
Phys this	11-	2 Accident investigation	(Month, Day Year) 188. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 Tes	s 2 No 281. Location	(Street and Number or Rura own, State)	Route Number,
Phys this	Certification: T	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) Injury 18e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 ☐ Yes	281. Location City or T	own, State)	
DIVISION OF Hospital or Attending Phys 4 hours after death. Funaral Director: After this ely filled in by the funeral of	Certification: T	2 Accident investigation 3 Suicide 6 Could not be determined 2	(Month, Day Year) Injury Re Place of Injury - At home, farm, st	M 1 ☐ Yes	281. Location City or T	own, State) e cause(s) and manner as st	ated.
DIVISION OF Hospital or Attending Phys 4 hours after death. Funaral Director: After this ely filled in by the funeral of	11-	2 Accident investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physicia (Check only 2 Medical Examiner:	(Month, Day Year) Injury 18e. Place of Injury - At home, farm, st building, etc. (Specify) an: To the best of my knowledge, dea. On the basis of examination and/or in	M 1 ☐ Yes reet, factory, office th occurred at the time, nvestigation, in my opini 29c. License n	281. Location City or T date and place, and due to the time umber	e cause(s) and manner as st e, date and place, and due to 29d. Date signed (Month, 1	ated. the cause(s)
Phys this	Certification: T	2 Accident investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 2 Accident investigation 2 2 Certifying Physicia 2 Medical Examiner:	(Month, Day Year) Injury 18e. Place of Injury - At home, farm, st building, etc. (Specify) an: To the best of my knowledge, dea. On the basis of examination and/or in	M 1 ☐ Yes reet, factory, office th occurred at the time, reestigation, in my opini	281. Location City or T date and place, and due to the time umber	own, State) e cause(s) and manner as st e, date and place, and due to	ated. the cause(s)
DIVISION OF Hospital or Attending Phys 4 hours after death. Funaral Director: After this ely filled in by the funeral of	Certification: T	2 Accident Could not be determined Accident Acc	(Month, Day Year) Injury 18e. Place of Injury - At home, farm, st building, etc. (Specify) an: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.	M 1 ☐ Yes reet, factory, office th occurred at the time, nvestigation, in my opini 29c. License n → 42.5	281. Location City or T date and place, and due to th ion, death occurred at the time	e cause(s) and manner as steed and place, and due to 29d. Date signed (Month. 4	ated. the cause(s)
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director and the funeral director.	Certification: T	2 Accident Could not be determined Accident Acc	(Month, Day Year) Injury 18e. Place of Injury - At home, farm, st building, etc. (Specify) an: To the best of my knowledge, dea On the basis of examination and/or in and manner stated. Section 1	M 1 Yes reet, factory, office th occurred at the time, nvestigation, in my opini 29c. License n > 42.5 Print) nter. #100.	281. Location City or T date and place, and due to th ion, death occurred at the time	e cause(s) and manner as steed and place, and due to 29d. Date signed (Month. 4	ated. the cause(s)

			For 1 State	State of Maryland	d / Depa	artme		alth and N	Mental Hy			6	131	88
_		التخو	Registrar 1. Decedent's Name (First, Middle, Las	11		Timoa	10 01 00		2. Date of Dea				3. Time of	Death
	Physicia	an	Λ -						Month y	Day		ear	24/2	
	/Medic		PIT AMELI.			Alta Cita	. Town orlo	anting of Dooth	HpmI	40	County of		276	77
1	Examin	er	4a. Facility Name (If not institution, give	street and number)				cation of Death	1					
			UNION HOSPITM	7 4 (1		+	er 1 Year If	Under 24 Hrs.	O Data of Birt		Car		lace (State of	r Foreign
	Funeral		5. Social Security Number 6. Sr 220–18–5422	7. Age (In yrs. Ia □ M 21☑ F 77	ast <i>birthday)</i> Yrs.	Months		lours Min.	8. Date of Birt (Month, Da March	v, Year)	29	Coun	ryland	rroreigi
	Director	-	Usual Residence of Decedent	77					nar on	,		naı	yrand	
	A A		10a. State 10b. County	10c. City	, Town or Le	ocation						1	0d. Inside Cit	ty Limits
	f show	5	Maryland Cecil				Conc	wingo					1 🗌 Yes	2 🛭 No
	28a-	ect	10e. Street and Number			10f. 2	ip Code			10g. Citi	zen of Wh	at Coun	try?	
	8 0	2	1157 Rock Sprin	ac Poad			2191	8			11	S.A.		
	within 72 hours after death with the maryland ene. 10. 11. In martinal, or items 23a or 28a-f show in Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	S 13.	Was Dec			pecify Yes or No	-	14. Race -			
	lter o	,	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, sp	ecify Cuban, N	Mexican, Puerto	pecify Yes or No p Rican, etc.)		Black,	White,	etc.	
ည် ဝ	l', or	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 ₺ № 5	Specify:			Specify:	Wh	ite	
9500-61212	itura al E	ed	15. Decedent's Ed	lucation	16a. Dece	dent's Us	ual Occupatio	n .		16b. Ki	nd of Busin	ness/Ind	dustry	
ဂ	o "ca	plet	(Specify only highest gra	de completed)	(Give lite.	kind of v DO NOT	rork done durii use retired)	ng most of wor	king					
7	than	Completed	Elementary/Secondary (0-12) Eleven Years	College (1-4or 5+)		Hon	nemaker			Pe	rsona	l R	esiden	ıce
	Hyg Hyg sther		17. Father's Name (First, Middle, Last)				18	. Mother's Nam	ne (First, Middle,	Maiden	Sumame)			
a	d be	o Be	George W.	Carr				An	melia M.	Bro	wn			
2	i z snoud be filed within h and Mental Hygiene. 7 is marked other than " fraumatic event, the Med	၀	19a. Informant's Name/Relationship (19b. Maili	ing Addre	ss (Street and		ral Route Numbe			ate, Zip	Code)	
Maryland	iges I and 2 should be lied within 7.2 hours affer death with the waryar to f Health and Menhal Hygiene. It id man 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evandrar must be notified at			aughter)	P.O.	Box	755. R	ising S	Sun, Mar	vlan	d 2	191	1	
a)	Heal Heal arm 2		20a. Method of Disposition	20b. P	ace of Disp	osition (N	ame of	Loring	Date		cation - Ci			
ဋ	iges in it of or o		1 Burial 2 □ Cremation 3 🗵	Removal from State Ple	emetery, cre asant G	matory of	other place) United	047	19/06	Doogh	Dotte		ennsylv	zania
Baltimore,	tant tant ijury		4 □ Donation 5 □ Other (Specific	// Met	nodist	Cemet	ery	1	13700	Peaci	botu	AII, F	emsyrv	аша
o o	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra		21. Signature of Funeral Service Liger	TOUR SON A	_ L	ee A.		rson &	Son Fun), P	.A.	
_	auzea		MONOGALI A	COORTAIN, OIL				Marylar		03-0	766		Approximate	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	i. Do not en	iter the m	ode or dying, s	uch as cardiac	or respiratory a	rrest,			Interval Bet	ween
F	hysician		Immediate Cause (Final disease or condition	· SEPSIS									1 WC	
	/Medical		resulting in death)	Due to (or as a consequ	ience of):									
2.6	Examiner		Sequentially list conditions,	b. RENAL	FAILUR	u							wcc	iL
<i>5</i> . v		ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consequ	ienes of):							T		
	certificate be executed ding physician and use as the burial-transit	Examiner	(nat initiated events	c								-		
o Î	an a an a rrial-i		resulting in death) Last	Due to (or as a consequ	ience of):									
760,	ite be iysici ne bu	cai		d										
9	that the death certificat ed by the attending phy detached for use as th	Completed by Physician/Medi	IS SERVALE.											
Вох	h cer endir use	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic	pregnancy			1	3d. Date		-	V
	death ie atter ed for u	icle	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at time of de 9☐Unknown		Other (Mont	1	Day 1	Year
O.	t the by th	hys	9 Unknown	3C OTIKITOWN										
ري ص	w requires that the been signed by the should be detache	Ϋ́	Part II. Other significant conditions of		0		cause given i	n Part I.	23e. Did t	obacco u			ne cause of d	
ğ	quire n sig uld b	be be	CHROMIC 05	structure,	Sung)	Discort	~	10	Yes 2	No 3	☐ Prob	ably 4 □L	Jnknowr
000		lete			L	/			24a. Was		24b. We	re auto	psy findings	available
æ	sician: The law certificate has b irector, page 2 s	щć								ormed?	dea	ith?	npletion of ca 2 □ No	ause or
Ö	n: T ficati or, pa	Ö	25. Was case referred to medical	_		-	20	Place of Dea	1 ☐ Yes			Yes	20 140	
Division of Vital Records,	Physician: this certific ral director,	8	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 201			lome 5 ☐ Resi		S □Othor	(Engoit	e1	
ot	> 0 0	- 1º	27. Manner of Death		28b. Time				28d. Describe				()	
n	ding Phy h. After thi funeral	tion	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No						
S	Attending r death. ctor: After by the fune	Certification:	3 Suicide 6 Could not b	e 29a Place of Injury . At he	me farm s	treet fact			28f. Location (Street an	d Number	or Rura	l Route Num	ber.
<u>≥</u>	or A after Direction by	iti	4 Homicide determined	building, etc. (Specify	()		,,		City or To	wn, State)			
_	spital or Attenours after death		29a. Certifier 1 Certifying Pl	nysician: To the best of my kno	wladae daa	th occurr	ad at the time	date and place	and due to the	causo(s)	and mann	er as si	ated	
	P F F P	edical	(Check only 2 Medical Example)	niner: On the basis of examina and manner stated.	tion and/or i	nvestigati	on, in my opini	on, death occu	rred at the time,	date and	place, an	d due to	the cause(s	;)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated.		1 5	9c. License n	umber		29d. Dat	e signed (Month.	Day, Year)	
	5 W I		Los. digitative and title of certified	- /					,					
	2		VIII.AM 7	for MO	,		7004	02759	'	A]	ΔT TT	тт,	2006	
	7		30. Name and address of person who	completed cause of death (Item	23a) (Type	, Print)	-	6		^				
	1		William T	Fors (6)	6 150	ل دحد	7 4	ICKTO.	I M)				
100	C+	ite	31. Date filed (Month, Day, Year) APR 1 9 2006	32. Megistrar s Signa	uie .	N. s								

			For State Registrar	State of Mary	land / I	-	ment of H		and Me		gienę leg. No	006	13189
	Physici	an	1. Decedent's Name (First, Middle, Last) Zariah Omaine	Ivey						2. Date of Dea Month		Year	3. Time of Death
<i>,</i>	/Medic Examin	al	4a. Facility Name (If not institution, give st			4b	. City, Town, or	Location o	of Death	t	4c. C	ounty of Deat	h
			PENIASUMA REGIONOR	Medicon C	BNOBA		رک Under 1 Year	If Under	4/4/ 24 Ars	9 Date of Birth		Wicsm	//Co hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex n/a 1□	4 00 4	n yrs. last bil 1/a		onths Days	Hours 20	Min.	8. Date of Birth (Month, Day 4/8/20	06 Year)	Co	cyland
	and **		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Tow	n or Location	on						10d. Inside City Limits
	Maryli f sho	tor	Maryland Wicomi	co	Sali	sbury							1. X Yes 2.☐No
	with the	i Directo	10e. Street and Number 609 Smith St.			1	Of. Zip Code 2180	01				on of What Co	ountry?
36	should be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "naturel", or liems 23e or 28e-f show imatic avent, the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S.	If Ye	Decedent of Hi s, specify Cuba Yes 2 No	ispanic Origin, Mexican	gin? (Spec n, Puerto P	cify Yes or No- lican, etc.)	1	Black, Whit	e, etc.
215-0036	n 72 hou "natural	Completed I	15. Decedent's Educ (Specify only highest grade	ation completed)	16a	(Give kind	's Usual Occupa f of work done o	during most	t of workin	g	16b. Kind	d of Business/	
212	d withi	d L L	Elementary/Secondary (0-12) n/a	College (1-4or 5+)		n/a					n/	′a	
and	\$ g a &	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Hughland Edward I	vey III						(First, Middle, Arisse			
Baltimore, Maryland 21	2 a a a	-	19a. Informant's Name/Relationship (Typ Dawn C. Hoeler/mot		198	-	ddress (Street a						Zip Code)
ore,	Pages 1 and nent of Health int: If Item 27 iry or other ti		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	1	cemete	ry, cremato	n (Name of ory or other plac			ite /OG		ation - City or	
altim	permit. Page Department o Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses	•/	Salis	22 Na HO.	Cremato Iloway	s of Facilit Funer	4/11, ål Ho	ome Pro	fessi	isbury onal <i>P</i>	Association
	80 = 90		23a. Part 1. Enter the disease, or complic	ations that caused the	death. Do	50.	L Snow I	HITT	Ra.,	Salisb	ury,	MD 218	Approximate Interval Between
/	Physician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	premat	urit)							Onset and Death
	Examiner	_	Sequentially list conditions, b.	Due to (or as a co			rssiun						
Ī	cuted nd ransit	Examiner	Sequentially list conditions, any, leading to fine clate cause. Enter Underlying Cause (Disease or injury that initiated events	llcon	tal	abr	tron	/					
8760,	cate be executed physicien and the burial-transit	dicai Ex	resulting in death) Last	Du to (or as a co	onsequence	of):							
Вох 6	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal deat		opic pregnancy her (specify)				23	d. Date of de Month	livery Day Year
ds, P.O.	w requires that the de been signed by the should be detached	þ	Part II. Dther significant conditions conf	nbuting to death but n	ot resulting	in the under	rlying cause give	en in Part I.			obacco use		o the cause of death?
Division of Vital Records,	i ician: The law rec certificate has bee rector, page 2 shor	Completed										24b. Were au prior to death? 1 Yes	utopsy findings available completion of cause of
Vita	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	ospital:			3□ DOA Oth	05	-	(Check only o			
n of	Phys this aldi	on: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	2 ER/O 28b.	Time of Injury	28c. Injun Work	y at k?	2	ne 5 Resident			cify)
ivisio		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, f Specify)			Yes 2 🗆		8f. Location (S City or Tox		Number or R	ural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edicai Ce	(Check only 2 Medical Examin	ician: To the best of m ar: On the basis of ex	amination a	ge, death oc nd/or invest	curred at the tin	ne, date an pinion, dea	nd place, a ath occurre	nd due to the	cause(s) a date and p	ind manner as	s stated. e to the cause(s)
	thin 2.	Med	29b. Signature and title of certifier	and manner stated	1.		29c. Licens	e number			29d. Date	signed (Mont	h, Day, Year)
	Ywith To			357			51	461					-2000
			30. Name and address of person who con Tames Rost	mpleted cause of deat	h (ftem 23a)	(Type, Prin	nt)	57.	SAL	4564m	1 M	0	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 2 200	32. egistrar's	Signature	Some	ואל		.,.				

06-02193 Jones, Toniette

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar			Certin	ficate of	Death			,	,	Reg. No.			
Physician		1. Decedent's Name (First, Midd	. ,								Date of D	eath	20	TA:	3. Time of Death
ledical Examin	er	Toniette Patı	rice Jone	S							Month March 3	0. 2006	Yea		8:56
		4a. Facility Name (if not institution 11631 Dorado Beach	-	number)		41:	. City, Town	n, or L	ocation of			40	County of Charles	of Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1	Year	If Under	24Hrs.	8. Date of	Birth (MM	/DD/YYYY	9. Birth	place (State or Foreign
Director		579-84-8061	1 M 2 XF		46	Yrs.		Days	Hours	Min.	May			Cour	hington, DC
ith the Maryland 23a or 28a-f show any notified at once.	jo	Usual Residence of Decedent 10a. State 10b. County Md Char 10e. Street and Number 11631 Dorado B		7	oc. City, To √a1do		10f. Zip Co	de 502		_		10g. Cit USA	zen of Wh		10d. Inside City Limits 1 Yes 2 No
s after death w ral", or items niner must be	by Funeral	3 Widowed 4 Di	farried Armed 1 Yes vorced If Yes, Give or Dates: ecify only highest g	eer .	No eted) 1	If Yes	Decedent of State of	No	Mexican, F specify:	Puerto Ri	can, etc.)		14. Race White Specify: Kind of Bu	e, etc. B1ac	
)36 hin 72 ie. than "	e	Elementary/Secondary (0-12)	College	(1-4 or 5+)		orking life. D	O NO	T use reti	red)		İ			
5-0036 Iled within 72 Hygiene. I other than 'the Medical	Completed	12				Program	n Anal	Lys	t			Fe	dera	1 Go	vernment
Figure 1		17. Father's Name (First, Middle	, Last)					18	8. Mother's	Name (F	irst, Middl	e, Maiden	Surname)		
2121 Duld be fi Mental marked		Talmadge Willia]	Ernes	tine	т	Jones	3		
ould ould a Me	<u> </u>	19a. Informant's Name/Relations	ship (Type, Print)			19b. Mailing	Address (Street	and Numb	er or Ru	ral Route N	lumber, C	ity or Tow	n, State,	Zip Code)
MD d 2 sho tth and n 27 is		Ernestine T. Po	oe - Motł	ıer		508 24	th St	:. 1	N.E.	Was	hing	on,	D.C.	200	002
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Degriment of Health and Mental Hygiene. Opportant: If item 27 is marked other thinging or other traumant.		20a. Method of Disposition			20b. Pla	ce of Dispositi	on (Name o	f cem	etery,		Date			City or T	own, State
Baltimore, permit. Pages I ar Department of Hea Opportant: If ite injury or other tr		1 Bunal 2 Crematio		from State		matory or othe		1 1			10.04				
it. Printer	-	4 Donation 5 Other S			наг	mony Me									
Baltin permit. Departm Cports injury o		21. Signature of Funeral Service	Licensee)										Home	e, Inc.
7	-	wayn in	llum				31 Geo					2001			
Physician /Medical		23a. Part I. Fater the disease, or failure. List only one cause	r complications tha e on each line.	caused th	e death. D	o not enter the	e mode of dy	/ing, s	uch as car	rdiac or re	espiratory	arrest, sh	ock, or hea	art	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease	a. AcuteCo	onary A	rtery Thi	rombosis									Death
		or condition resulting in death)	Due to (or a	s a consequ	uence of):					-,,					
,	.	Sequentially list conditions,	_{b.} Hyperten	sive Ath	eroscler	otic Cardic	vascular	Dise	ease						
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or a	a conseq	uence of):										
	Ē	(Disease or injury that initiated	c. Due to (or a	2 500000	uonoo ofi:										
nsit ed	Ĭ	events resulting in death) Last	Due to (or a	s a consequ	derice or).										
xecur and and	<u> </u>	LUIDEUDED	a			·									
760, reate be executed physician and the burial - transit	ğ	UNPENDED	AMENDE												
ox 68° ath certiff attending or use as		IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 ✓ Un	the 1 Liv	s, outcome e birth gnant at tir known		2 Feta	il death er (Specify)	3	Ectopic	pregnanc	E y	23	d. Date of Month	delivery Da	y Year
P.O. Bot that the decord to detached for		Part II. Other significant condi	tions contributing	to death b	out not resu	ulting in the ur	derlying car	use giv	ven in Parl	t I.	23e. Di	tobacco	use contri	bute to th	e cause of death?
P.O. irres that the signed by I be detact	5										1 🔲	Yes 2	No 3	Proba	bly 4 🗸 Unknown
Division of Vital Records, lat or Attending Physician: The law require rs after death. al Director: After this certificate has been si ded in by the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director beginning.	Completed				-		***************************************				pe	as an topsy rformed? s 2	p		opsy findings available impletion of cause of
Vital Recysician: The his certificate director, page	Be De	25. Was case referred to medica	al				26.F	Place	of Death (0	Check on		- Land			
/itt	n	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 E	R/Outpatient	3 DOA	C	ther4	Nursing I	Home 5	Reside	ence 6 v	Other:	Scene
ing Phy	<u> </u>	27. Manner of Death	28a. Da	te of Injury		8b. Time of Inj		Injury	at Work?				ury occurre		
ion of tending Pheath.	5	1 Natural 5 Pen	(Mo	te of Injury nth, Day,Yea	г)	,			es 2 1				,	-	
IVISION OF Attence after death Director: In by the	cat		estigation	1-i											
Divisi pital or At ours after d eral Direct filled in by	Certification:	4 Homicide dete	lld not be ermined (Special		y - At nom	e, farm, street	, factory, on	ice bu	ilding, etc.	. 28	or Town		and Numbe	er or Rura	Route Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	edical	one) 2 Medical Exa	and manne	is of exami											
	Ξ	29b. Signature and title of certification	er			1	29c. Li	cense	number			29d.	Date signe	ed (Mont	h, Day, Year)
5	-	Caroe r	tall.	au	M	0	0	.C.N	1.E.			Ma	rch 31, 2	2006	
			ssistant Medica	al Exami	ner 1	^{3a)} 11 Penn S	treet, Bal	timo	re, MD	21201					
Sta Registra	te ar	31. Date filed (Month PRY, Year)	2 2006 32.	-gistrar's	Signatu	April									
DHMH 17 Rev 1/200	11					OPIGINAL									

OCME 10/2003

			1- State of Maryland / Department of Health and Certificate of Death	Men	, ,	ene 0 0 6	319
H	Physici	an	1. Decedent's Name (First, Middle, Last)		ate of Death	Day Year	3. Time of Death
	/Medic	al	Anthony U Johnson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	ath	4 0	4c. County of Deat	9:10 A M
L	LAGIIIII	- I	Coostel Hospin po Box 1733 Solisbury Mi	D		Willow	1110
	Funeral Director		5. Social Security Number 2 6. Sex 2 F 7. Age (In yrs. last birthday) If Under 1 Year () If Under 24 H Yrs. Months Days Hours Mi		Date of Birth Month, Day, Y	(ear) 9. Birth	hplace (State or Foreign untry)
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Mary	ctor	Md. Prince George Bowie				1 Yes 2 No
	deeth with the Maryland me 23a or 28a-f ehow rickst be collified at	Funeral Director	106. Street and Number 104. Zip Code 2016		100	. Citizen of What Co	untry?
	ame 23	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? If Yes specify Cuban Mexican Pur	(Specify	Yes or No-	14. Race - Ame Black, White	
0000	be filed within 72 hours after tal Hygiene. d other than "natural", or its event, the Madical Expiring	by Fu	1 Never Married 2 Married 1 Never Married 2 No Specify: 1 Yes, Give 1 Year or Dates: 1994		,,	Specify: R	lack
2	72 hou "nature		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	vorking	16	b. Kind of Business/	Industry
7 7	d within giene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		n	14/4:-5	ervicer
aud	be filed with stal Hygiene od other than event, me s	Be	17. Father's Name (First, Middle, Last) 18. Mother's N	lame (Fir	st, Middle, Ma	iden Sumame)	
ar yie	2 should to and Ment is marked eumatic	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Nural Roi		MOUS City or Town, State, Z	lip Code)
ž.	end 2 eelth a m 27 is her tre		Linda Bower (Sister) 120 Schoolfield Street	et 1	Berlio	md. 2	1811
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Depertment of Health and Marylar Higher Breatment of Health and Marylar Higher Ham "natural", or itame 23e or 28e-f ehow morter: if item 27 is marked other than "natural", or itame 23e or 28e-f ehow any injury or other treumatic event, in a Marklaal Exam are must be notified at once.		20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Date		c. Location - City or	,
allimo	permit. P Depertme importen any injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Penn	lie Sn	Olomake	eral Hanc
Ω	89 2 2			and	oke C	ty rd.	2 / SJ Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		pliatory arres		Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. We a Stall to o o n Cantal to o o n Due to (or as a consequence of):		-		
Ę		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
0/0C,	cate be executed physicien and the burial-transit	dicai E	d				
	ertificat	Medi	IF FEMALE:				
ממ	sicien: The law requires that the death certific certificate has been signed by the ettending, rector, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of deli Month	very Day Year
Γ Σ	at the	Phys	9 □ Unknown		00- Dili-	cco use contribute to	th (d 1) ()
cords,	tuires the signer of signer of signer of the d	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_	23e. Did tobai		bably 4 Unknown
<u>ဂ</u> သ	taw rec as bee	ompleted			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
	n: The ticete ha	O			performe □ Yes 22	? death?	21 X 10
<u> </u>	Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes		ce 6 ☐Other (Spec	ify)	
5	ding Pt h. After th funeral		27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Unique Work? Injury M 1 Yes 2 No	28d. I	Describe how	injury occurred	
NISION	To the Hospital or Attending Physician: white 24 hours site deals. To the Funerel Director: After this cardioc completely filled in by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Stre	et and Number or Ru State)	ral Route Number.
5	pitel or ours eft erei Di filled in		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.				
	ro the Hospitel or within 24 hours efte To the Funerel Dir completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	curred at	the time, date	and place, and due	to the cause(s)
	To t To t	×	29b. Signature and title of certifier 29c. License number	70	29d	Date signed (Month	, Day, Year)
	44.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daired County, MD Coastol Hospiu po Box 1733	<i>8</i>	, ,	1/1-106	
E	7 24			رمسل	11660	, mis	21802
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2006 32. Jegistrar's Signature				

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physician: death.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Joseph Benedict Jenkins APRIL 08,2006 10:38 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. CIVISTA MEDICAL CENTER CHARLES 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F 75 Yrs 217-28-7821 March 11,1931 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Charles Nanjemov 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? "natural", or Itame 23a or 9595 Ironsides Road 20662 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, In a Madic one. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Heating & Electric Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delbert Jenkins Viola C. Padgett Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jenkins Wife 9595 Ironsides Rd., Nanjemoy, Md. 20662 20b. Place of Disposition (Name of cometery, crematory or other place)

Maryland Veterans Cemetery

April 13, 2006 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility M00668 M270 Hawthorne Road, Indian Head, Md. 20640

Approximate Interval Betwee Conset and Dead Resulting in death)

M00668 M270 Hawthorne Road, Indian Head, Md. 20640

Approximate Interval Betwee Conset and Dead Resulting in death) Approximate Interval Between Onset and Death Residuatory
Due to (or as a consequence of): Few JAYS CHRONIC OBSTRUCTIVE FULLWESTRY DISEASE MANY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine CORON ART D158A38 ARTERT that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria FAILURZ HAN'T YEARL Physician/Medical CONCESTIVE A 2 ART the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ UALUZ NEPLACE HEND 1 Yes 2 No 3 Probably 4 UpKnown FIBAILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 Tyes 2 No investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/8/06 D-21173 wil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRAN P. SHARMA, MD 3460 OLD WASH.RD. SUITE 203A WALDORF,MD. 20602 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician .Month Gustaf Bertil Johansson pnil 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICS Mallox PONINSULA ROGISNAL CONTEX SAUSBUM If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Se: 8. Date of Birth (Month, Day, Ye 7/2/1924 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1**⊠**M 2□F 107-18-7644 81 Director Sweden Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits ir than "natural", or items 23e or 28a-f ehow tra Medical Examinar must be notified at X Yes 2 No Director Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after deeth with 105 Autumn Lane 21826 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2X ves 2 22 No If Yes, Give Year or Dates: Navy Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Supervisor Electrical traumatic event, permit. Pages 1 end 2 should be file Department of Heelth and Mental Hy Importent: if flem 27 is marked oth any injury or other traumatic event pice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Johansson (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry R. Johansson/son 105 Autumn Lane, Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Salisbury, MD 4/10/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ACTIONAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Runney 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FEATON TOROITO BY INTO THE ELANMER 12 Hows assiration /Medical Due to (or as a consequence of) Examiner gas Sequentially list conditions, if any, leading to immediate cause. Enter United Injury Cause (Disease or injury Due to (or as consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) cete hes been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 0 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, disease 1 Yes 2 No 3 Probably 4 Unknown Coronar 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes 2☑No 1 Yes 2 No or Attending Physicien: Medical Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred Division 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A completely filled in by the fu investigation 04/05/2006 Unknown^M 1 ☐ Yes 2 ▼ No Subject fell 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State).

105 Autumn Lane, Fruitland, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

At home 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date sighed (Month, Dey, Year) 8/06 D30853 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennsula Regional Medical Center Silvin Jr my 13

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 2 2006

ORIGINAL

32. Pogistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Time of Death Month Vear 00 **Physician** AM Jones Helen Armstrong 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CITIZENS BISTA AVR JRACE If Under 24 Hrs. If Under 1 Year 8. Date of Birth Month, Day 9/12/19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1□M 2**X**F Months Davs Hours Maryland 219-01-4848 86 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at Yes 2 No Director Harford Havre de Grace Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 21078 or Itama 23a 312 Revolution Street Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2X No Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 212 No Specify Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) US Government civil service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental I ant: If itam 27 is marked of Thomas Armstrong Nellie McDonald John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 262 Revolution St., Havre de Grace, MD 21078 Charles C. Jones, Jr. (son) othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. R.A.Ferris & Co., Inc. 4/21/06 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. End of Janging Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown Day 4□Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law page 2 autopsy 1 ☐ Yes VZ No or Attanding Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar DHMH 17 Rev 1/2001

within 2 To tha

(Check only one)

31. Date filed (Month, Day, Year)

APR 2 6 2006

29b. Signature and

completed cause of death (Item 23a) (Type Print)

2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

	1	For State Registrar	State of Marylan		irtment of I tificate of			ne . 2 . 0 0 6	13195
Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month April 5	Day Year	3. Time of Death
/Medica Examine	A	Sara Kelle 4a. Facility Name (If not institution, give si Anne Arundel Me	reet and number)	r	4b. City, Town, Annay	or Location of Death	1	4c. County of Death Anne Aru	
Funeral Director		5. Social Security Number 6. Sex 428-58-5303	7. Age (In yrs.	last birthday) 91 yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day Y NOV 24	9. Birthn Court 1914 Mis	place (State or Fore ntry) SISSIPPI
aryland show		Usual Residence of Decedent 10a. State 10b. County Marvland Anne Ar		y,TownorLo					10d. Inside City Limi
in the Mi	<u> </u>	Maryland Anne Ar 10e. Street and Number	under An	Парот	10f. Zip Code		10g	. Citizen of What Cou	
filer death v	runeral	1906 Lincoln Dr 11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ⅓No		2140	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	USA 14. Race - America Black, White,	etc.
n 72 hours ("natural", o	Completed by	\$\infty\text{Y\text{Vidowed}} 4 □ Divorced 15. Decedent's Educ (Specify only highest grade)	Year or Dates: ation completed)	16a. Deced	lent's Usual Occu	pation during most of wo		Specify: B1 a	
filed within I Hygiene. other than	ne Comp	Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Nu	rse		ne (First, Middle, Ma	OWnsvill	e Hospit
thould be id Menta marked matic ev	0	Gilbert Andrews 19a. Informant's Name/Relationship (Type	ne, Print)	19b. Mailin	g Address (Stree		eterson	City or Town, State, Zip	Code)
jes 1 and 2 s of Health an if Item 27 is or other trau	(Christine Ladner 20a. Method of Disposition 1 X Burial 2 Cremation 3 CR	(Daughter) 20b. F	1906	Linco	In Dr. A	nnapolis	o. Location - City or To	401 own, State
permit. Pag Department Importent: any Injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		₩		ss of Facility on	s Mortua	napolis, ry, P.A. Md. 214	
cate be executed /Medical Examiner and sthe burial-transit	Exa	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	h. Do not enti-	er the mode of dy	ing, such as cardiai		t,	Approximate Interval Between Onset and Death Aay
death certifi e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 \(\text{Yes} \) 2 \(\text{IP} \text{No} \) 9 \(\text{Unknown} \)	ic. If yes, outcome of pregni 1	il death 3	Ectopic pregnani Other (specify)	су		23d. Date of deliv	ery Day Year
es ti	2	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t	the cause of death?
as as b	Completed						24a. Was an autopsy performe	prior to co	opsy findings availal ompletion of cause of
cian	Be	25. Was case referred to medical examiner?	ospital:			thon	ath (Check only one)		
ding Phye	tion: To	1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Dinpatient 2 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 Nursing r	tome 5 Residen	ce 6 Other (Speci	<u>(v)</u>
To the Hospitel or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str	eet, factory, office	3	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
e Hospitel (24 hours ar Eunerel Dietely filled i	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my known: On the basis of examination and manner stated.	owledge, deatl ation and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occi	e, and due to the cau urred at the time, date	se(s) and manner as se and place, and due t	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and tiple of certifier	1 12		29c. Licer	13199	290 A	d. Date signed (Month,	Day, Year)
		30. Name and address of person who co		1 ~		Anna	olis, Mo	Olyni	
Stat Registra	e	Trank Lin, 40. 31. Date filed (Month, Day, Year) APR 11 200	2. Registrar's Signa		skeway	ririapo	MIS, MID	2170	

			For State Registrar	State of Ma		partment of H e <i>rtificate of l</i>			Jiene () () ()	13196
ı	Physici		1. Decedent's Name (First, Middle, Las Joseph Francis Ki					2. Date of Dea Month April 9	Dav Yea	3. Time of Death 3:00 p. M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	Т	4c. County of De	
	LXamin	٠.	Charlotte Hall Ve	terans Hor	ne	Charlotte	e Hall		St. Mar	v
	Euporal		5. Social Security Number 6. Sec	ex 7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		tirthplace (State or Foreign Country)
	Funeral Director		579-05-8429	X ^{M 2□F} 96		Months Days	Hours Min.	April April	10,1909 Wa	ishington D.C.
	death with the Maryland me 23s or 28s-f ehow froust be notified at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Ma P-f	Funeral Director	maryland Charles	S	Indian I	lead				1¼ Yes 2 □ No
	h th	i e	10e. Street and Number			10f, Zip Code		1	10g. Citizen of What	Country?
	h wit	<u>e</u>	30 Cypress Place			20640	0		U.S.A.	
	deat	Jer	11. Marital Status	12. Was Decedent I	ever in U.S. 1	3. Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-		nerican Indian,
215-0036	after or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces? 1 ∰Yes 2 ☐ N If Yes , Give Year or Dates:	lo	1 ☐ Yes 2 ☐ No	Specify:	rican, etc.)	Specific	hite Mite
ş	4 5 5	Pe	15. Decedent's Ed	lucation	16a. De	cedent's Usual Occup	ation		16b. Kind of Busines	ss/Industry
2	in 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	life	cedent's Usual Occup ve kind of work done o DO NOT use retired	during most or worki f)	ing		
	d within giene. r then "	E	9	Conage (1-4013	Refi	rig & A/C :	[rech		U.S. Gove	rnment
0	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	
<u>a</u>	lid be hental ked c	To B	Henry F. King				Clara	Doi	rr	
<u></u>	and M smar sumat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	illing Address (Street	and Number or Rura	al Route Number	r, City or Town, State	, Zip Code)
Z	d ta		Dennis F. King	Son	731	5 Summit	Ave., Che	vv Chase	e. Md. 208	15
ā,	s 1 and f Heeli ltem 2 other		20a. Method of Disposition			position (Name of rematory or other place		Date	20c. Location - City	
Baitimore,	00		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		i	ction Cemet	April 1	2,2006	Clinton,	Maryland
alt	permit. Page Department Important: ti any Injury o		21. Signature of Funeral Services Licen	See /			-			
α	88559		21. Signature of Funeral Repuise Licen 23a. Part1. Enter the disbase, or come shock, or heart failure. List only	lan	M00668	W1111ams I	runeral H	ome, P.A	A. D. Hoad Md	20640
ı			23a. Part1. Enter the disease, or com-	plications that caused	the death. Do not	enter the mode of dyin	g, such as cardiac of	or respiratory arr	rest,	Approximate Interval Between
	Dhysisian		mmediate Cause (Fina)	one cause on each in	0.					Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. OVO	SCASI a consequence of):					
	Examiner			Ca	a consequence on).	200.00 H	2			
		-	Sequentially list conditions if any leading to immediate	b. Due to (or as	a consequence of):	evryre	mia			-
	pet nsit	i i	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sai	110 =	erry H	MANE	P.		
	xecu al-tra	Examiner	that initiated events resulting in death) Last		a consequence of):	013	OFFICE	,		
6876 0,	ificate be executed g physicien and as the burial-transit	aiE								
8	ficate p physics ts the	edicai		. 0						
_		We	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of c	tolivon
ROX	death certifi e ettending od for use as	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	•		Month	Day Year
j	D 0 D	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown	tano or obdar					
٦.	that I	4	Part II. Other significant conditions c	ontributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Vital Records,	The law requires that the tite has been signed by the bage 2 should be detache	Completed by	hyperten	sion				1 □ Y	es 2 🗆 No 3 🗇	Probably 4 Unknown
Ö	w require been si should b	ete	A						100 111	
ခ္	e law has t	Idu	memu	<u>o</u>				24a. Was a autops	sy prior t	autopsy findings available o completion of cause of ?
=		Ö						1 ☐ Yes	No 1 Y	es 2 No
Ita	Physician: The lavithis certificete has al director, page 2	Be	25. Was case referred to medical examiner?	14		100	26. Place of Deatl		-	
	hysi his c	မ	1 ☐ Yes 2 💢 No		nt 2 ER/Outpa		4 Nursing no		ence 6 Other (S)	pecify)
Ē	Attending Physician: or death. ector: After this certific by the funeral director.	lon:	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time (Year) Injur	y Wor		28d. Describe h	ow injury occurred	
<u>s</u>	tend eath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No			
Division of	l or Attendation after deati	Certification:	4 Homicide determined	28e. Place of Injuding, et	ury - At home, farm, c. (Specify)	street, factory, office		281. Location (S City or Tow	itreet and Number or m, State)	Hural Houte Number,
_	pital purs a erel l		29a, Certifier 12 Certifying Ph	ysician: To the best	of my knowledge, de	and a converse of the tree	no data and place	and due to the e		an atotad
	To the Hospital or Attenwihin 24 hours after deal To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical Example)	niner: On the basis of and manner sta	examination and/o	investigation, in my o	pinion, death occur	red at the time, d	date and place, and d	ue to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier	01		29c. Licens	e number	2	29d. Date signed (Mo	nth, Day, Year)
)			V/m. 0	Ham	· mx	D43	5092		4 10	2006
	14+1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Print)	,1	,	1, 1	
	in Ale		110 Hospital	Road	of Su	te # 20	5, Hr	intin	gtown	MD 20639
	Sta		31. Date filed (Month, Day, Year)		ar's Signature		, , ,		(
	Regist	ar	APR 12;	2006 6000	w St. A	melle				

		1 - For State Registrar		of Maryla	-	artmen rtificat			ind M		Reg. N	UU	6	131	97
Physicia /Medic	al	1. Decedent's Name (First, Middle Elsa	Kahn							2. Date of I Month April	11,	2006		3. Time o	
Examin	er	4a. Facility Name (If not institution Genesis Elder 5. Social Security Number			. last birthday)			Location of Plat	ta	8. Date of I		4c. County	Char		or Foreign
Funeral Director		215-92-0545 Usual Residence of Decedent	1□M 2Ū X F		• •	Months	Days	Hours		DEC . 1	Day, Үөа б ,	899	GERI	place (State of the other) MANY	or r oreign
ha Marylan 8a-f ahow otified at	Director	10a. State 10b. County Maryland Char	les	10c. C	La P	lata					7				ity Limits 2 □ No
with t	i Dir	10e. Street and Number 1 Magnolia Driv	70			10f. Zip	Code 20 6	. <i>I.</i> C			10g. 0	Citizen of V		ntry?	
is 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menale Hygiens. If Health and Menale Hygiens is filem 27 is marked other than 'natural', or flams 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified.	ed by Funerai	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was De Armed 1 □ Yes If Yes, 0	ecedent Ever in I Forces? s 2 XNo Give Dates:	1	1 🗆 Yes	dent of Hi cify Cubar 2 X No	spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto f	city Yes or I		Specify	e - Americk, White,	ite	
within 72 lana. than "na	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade complete	d) 9 (1-4or 5+)	(Give		rk done d se retired,	urina most	of workir	ng	100.	Own 1		austry	
d 2 should be filad within h and Mental Hygiana. 7 ia marked other than "Iraumatic avant, the Mer	To Be C	17. Father's Name (First, Middle, Moses Gras	Last)						r's Name	(First, Midd	lle, Maide				
and 2 shou aalth and M m 27 ia mai		19a. Informant's Name/Relations Peggy Garner -		ıghter		-				And, W					
parmit. Pages 1 and 2 Dapartment of Health a important: if ttam 27 is any injury or other tra		20a. Method of Disposition 1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		m State	Place of Dispo cemetery, crer rinity	sition (Nar	ne of ther place	9)	D	ate	20c.	Location -	City or To		
parmit. Dapartri importa any inju		21. Signature of Funeral Service	Seran Suran	M00053	22	. Name ar	d Addres	s of Facility	y	3035	01d		ingt	on Roa	ıd
Physician /Medical Examiner by spicial and prial-transit the prial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	to (or as a conse	quence of):		771		<u> </u>	TEN!		<u> </u>		zur	
The law raquiras that tha daath cartifics ate has been signad by tha attending pt paga 2 should ba datached for usa as t	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregree birth 2 Fee grant at time of known	tal death 3	Ectopic pi Other (sp						23d. Dati Mor		,	Year
quiras that n signad b	by P	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying c	ause give	n in Part I.				V		he cause of o	
The law raquir ate has been s paga 2 should	Completed										topsy rformed?	, ,	Vere auto prior to co leath?	opsy findings impletion of c	available cause of
sician cartifi rector	o Be	25. Was case referred to medical examiner?	Hospital:				. Othe	- /		Check only	-				
g Phy ar this aral di	1	1 ☐ Yes 2 No 27. Manner of Death	28a. Dai	te of Injury	28b. Time of		28c. Injury Work	ACTIVUE		ne 5 Re 28d. Describ				(y)	
andin tath. or: Aft ha fun	atio	1 Natural 5 Pendin 2 Accident investig	ation	onth, Day Year)	Injury	м		? ∕es 2□N	10						
ital or Att irs aftar di rai Diracti lad in by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Pla	ice of Injury - At l ilding, etc. (Spec	sify)					City or 1	own, Sta	ate)		al Route Nun	nber,
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerell Director: Attent this cardificate has completely filled in by the funeral director, page 2	ledicai	one) 2 Medical	g Physician: To t Examiner: On the and ma	the best of my kr basis of examinanner stated.	nowledge, death nation and/or in	vestigation	, in my op	inion, death	d place, a h occurre	and due to the	e, date a	(s) and ma and place, a	nner as s and due to	stated. the cause(s	s)
To To Corr	W	29b. Signature and title of certified	ANX		W 330) Turn)	. License	number 0	62	2G.	29d. C	Date signed	(Month	Day, Year)	5
363		George (H. Wath	who completed ca ien, MD,	-			., #1	103, h	va]do	orf, M	ID 20	0603			
Sta Registr		31. Date filed (Month, Day, Year)		. Registrar's Sign	nature		j								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Day Year Daniel Johnathan Kline 2006 4c. County of Death 4b. City. Town, or Location of Death Washington

Maryland

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

29d. Date signed (Month, Dav. Year)

-20.06

1 XYes 2 No

1 - For State Registrat 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Fecility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown 6. Sex 1. M 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Yrs. 1932 74 April 3, Director 214-32-2559 Usual Residence of Decedent 10a. State 10c. City, Town or Location If item 27 is marked other then "natural", or items 23s or 28s-1 show or other traumatic event, it is Musical Examinar must be notified at Director Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. 601 Highland Way Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other then "natural; or Ites eny injury or other traumatic event, It a Medical Examinations. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisy Oliver Brunner John Russell Kline 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 335 Linganore Ave. Hagerstown, Maryland 21740 Rose M. Knode (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2006 20c. Location - City or Town, State 20a. Method of Disposition 1 Daurial 2 Cremation 3 Removal from State April 24, Garfield, Maryland Garfield Cemetery 4 ☐ Donation 5 ☐ Other (Specify) J.L. Davis Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** eschemic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical P þ Completed certificate has Be ٩

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

F FEMALE: (3b) Was decedent pregring the past 12 month 1 Yes 2 No 9 Unknown	saint	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	il death 3 □Ectopic	pregnancy (specify)		2	3d. Date of de Month	livery Day	Year
art II. Other significent.	conditions cont	nbuting to death but not res	ulting in the underlying	g cause given in Part I.		23e. Did tobacco u: 1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 PNo	No 3 P	robably 4	Inknown ings available of cause of
5. Was case referred to	medical			26. Place of De	eath (Ch				
examiner?	He	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home	5 Residence	Other (Spe	ecify)	
7. Manner of Death 1 Natural 5	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d.	Describe how injury	y occurred		
3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac fy)	ory, office		Location (Street and City or Town, State,		lural Route	Number,

29c. License number

angus Rd

3 State Registrar

Certification:

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32/Registrar's Signature

30. Name and addre s if person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

		•	For State of Mary		artment of H			iene	3199
	S 2000		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
П	Physicia /Medic		Patricia Ann	Kline			April	18 20	
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of	Death
			Union Hospital 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	E1kton	If Under 24 Hrs.	8. Date of Birth	Cecil). Birthplace (State or Foreign
	Funeral Director		215-34-5937 1 M 2 F 67	Yrs.	Months Days	Hours Min.	May 23,	1938	Maryland
12 4	о О		Usual Residence of Decedent						
	anylan show	_		c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	ecto	Maryland Cecil	E1kton	10f, Zip Code		11	0g. Citizen of Whi	A
	with with the or it	급	120 Walnut Lane		21921			United	·
	me 23	era	11 Marital Status 12. Was Decedent Ever		Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race -	American Indian,
9	or ite	by Funeral Director	1 Never Married 2 Married 1 Yes, 2 MNo If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	o Hican, etc.)	Specify:	White, etc.
00	urai',	d by	3 Wildowed 4 Divorced Year or Dates:						White
15	filed within 72 hours after death with the Maryland Hygiene. Yether than "natural; or iteme 23a or 28a-f ehow ent, Ira Medical Evant or must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	king	16b. Kind of Busia	ness/Industry
12	l withi	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		ner/Opera	•		Delicate	essen/Market
Maryland 21215-0036	e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, A	Maiden Sumame)	
ylaı	Menta Menta arkad	To	Arthur Murphy			Olive W			
Jar	2 sho		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street				
e,	1 and Health em 27 ther t	. 3	Thomas J. Kline/Husband 20a. Method of Disposition 2	Ob. Place of Dispo	Walnut La	1	Date :	Land Z19 20c. Location - Ci	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show apprintury or other traumatic event, tra Medical Eversinal must be notified at any injury or other traumatic event, tra Medical Eversinal must be notified at another.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	Gilpin Ma	matory or other place	9) Apri 2006	il 22,		Maryland
Ė	naft. P partme cortan injur		21. Signature of Funeral Service Licensee	Memorial	Park 2. Name and Addres			LIKCOII,	rial y Land
m	Departed Important Importa	8 X	Donald S. Hecko	10	ocks Home 33 W. Sto	for Func ckton St	erals, P. reet. Elk	A. ton. Mar	ryland 21921
	ż.		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ric L	upus F	ナルマ	emato	412	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a co	nsequence of):	upus F	1 . 1			1.2
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	insequence of):	No He	-borging	4, 5		10415
1/	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	2					10 yrs
V O	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a co	nsequence of):					
8760,	cate be executed physicien and the burial-transit	dicai	d.						_
9	leath certific attending pl	/Med	IF FEMALE: 23c. If yes, outcome of p	regnancy				22d Date	of delivery
Вох	death certific e attending p od for use as	Physician/Me	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
P.O.	0 0 0	hysi	1 Yes 2 No 9 Unknown 9 Unknown						
s, P	requires thet the	by P	Part II. Other significant conditions contributing to death but no	t resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	oacco use contrib	ute to the cause of death?
ord	w require been sij should b						1 1	s 2□No 3	Probably 4 Unknown
of Vital Record	aw 2 s t	Completed					24a. Was ar autops	y pric	ere autopsy findings available
三田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田	Th ate pag						perform 1 Yes 2		ath?]Yes 2☐No
Vit		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 Outpatier	nt 3 DOA Oth	oc	ith <i>(Check only on</i> lome 5 ☐ Reside		(C
o	Physe eral di	n; To	27. Mann Death 28a. Date of Injury	28b. Time o				w intury occurred	
ion	Attending ir death. ector: Afte by the fune	atlo	2 Accident investigation	pa <i>r)</i> Injury		Yes 2□No			
Division	or Atterde	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (S	At home, farm, str ipecify)	reet, factory, office		28f. Location (St. City or Town		or Rural Route Number,
Ω	Hospital of hours of Funeral D		29a. Certifier 1 Certifying Physician: To the best of m	v kasuladas dast	th accurred at the time	no date and place	and due to the or	auco(s) and man	nos as etatod
	24 hc 24 hc Fun etely	edicai	(Check only one) 2 Medical Examiner: On the basis of oxe and manner stated.	amination and/or in	ivestigation, in my o	pinion, death occu	rred at the time, d	ate and place, an	d due to the cause(s)
	To the Hospital or Attending Is within 24 hours efter death. To the Funeral Director: Atter completely filled in by the funer	Me	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed ((Month, Day, Year)
	-		Joe WW. W. D.		DHL	1716	A	Pril 19	1,2006
	- /-		30. Name and address of person who completed cause of death	(Item 23a) (Type,		Ma, M.D.			
	6		31. Date filed (Month, Day, Year) 32. Registrar's	Kton	U.W	, , 219	21.		
•	Sta Regista		31. Date filed (Month, Day, Year) 32. Registrar's APR 2 6 2006	& GOBY	W.				

			1 - For State Registrar	State	of Marylan		artmen			and M	ental Hygi	ene	16	13200
ı	Physici		1. Decedent's Name (First, Midd. Martin	James	Leader						2. Date of Death April 9		Year	3. Time of Death 10:15A M
	/Medic Examin		4a. Facility Name (If not institution Arden Court	s Nursing	•		Si	lver	Location o	ng		4c. County Mont		
I	Funeral Director		5. Social Security Number 218-16-2078	6. Sex 1 M 2 □ F	7. Age (In yrs. I 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth OCT 27,	^Y 1923	9. Birth Cou Ma	place (State or Foreign ntry) ryland
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	the Mar 28a-f si	ector	Maryland Mont	gomery	Si	lver S	_				140	- 0%		1 ☐ Yes 24 ☐ No
	th with 1 23a or 3	ai Dir	2416 Countrys	ide Drive			10f. Zip		905			g. Citizen of V ted St		of America
9036	be filed within 72 hours after death with the Maryland at lygiene. A lygiene by defect the "natural", or items 23a or 28a-f show of other then "natural", or items a natural be indiffied at event, the Madical Examiner and the indiffied at	I by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	Acmoed F	edent Ever in U. orces? 2 No ive Dates: 1943-		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto l	ocify Yes or No- Rican, etc.)	Blac	e - Ameri ck, White, Whi	
Baltimore, Maryland 21215-0036	within 72 h ene. then "natu he Medical	Completed		nt's Education st grade completed, College	1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired,	luring most)		ng	6b. Kind of Bu		ndustry ntracting
and 2	be filed within tal Hygiene. od other then 'event, the Ne	O	17. Father's Name (First, Middle, Unknow			Con	LIACE	Aun		r's Name	(First, Middle, Mi			neraceing
aryla	should be and Mental marked c umatic eve	To	19a. Informant's Name/Relations			19b. Mailie	ng Address	(Street a	and Numbe		l Route Number,	City or Town,	State, Zij	o Code)
e, Z	1 and 2 Health a am 27 lo		Selma H. Leader	- Wife	20h P						e, Silve	r Spri		
MO	Pages nent of th int: If It, iry or o		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (5			lace of Dispo emetery, crer Linco			ory	04/1				Maryland
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any Injury or other traumatic es once.		21. Signature of Funeral Service	Licensee										Home, Inc. g, MD 20904
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	complications that only one cause on	caused the death	n. Do not ent		e of dying		cardiac o	r respiratory arres			Approximate Interval Between Onset and Death
i.	/Medical Examiner		resulting in death)	Due to	(or as a consequ	1100	, J	1) K					
,00	cate be executed thysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to infirmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a consequ									
68760,	fficate b g physic as the b	edicai		d.										
P.O. Box	the death certifice y the attending ph iched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live	itcome of pregna birth 2 ∏Fetal nant at time of de nown	death 3	Ectopic pro					23d. Dat Mo	e of deliv	ery Day Year
	The law requires thet the de ste hes been signed by the a page 2 should be detached	Ď	Part II. Other significant conditions of the Part II. Other signif	ons contributing to a	leath but not resu	ulting in the u	nderlying ca	ause give	on in Part I.			icco use cont		he cause of death? bably 4 ⊟Unknown
I Records,	The law resete hes be	Completed		·							24a. Was an autopsy perform	ed?		opsy findings avaitable ompletion of cause of
Vita	Physiclan: r this certific ral director,	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 🗆	ER/Outpatier	y 3□ DO	Othe	NP		(Check only one)		or /Coos	6.1
on of	sing Phy I. After thii funeral c		27. Manner of Death 1 Natural 5 □ Pendin	28a. Date (Mor		28b. Time of Injury		8c. Injury Work		2	28d. Describe how			9)
Division of Vital	To the Hospital or Attending Physician: The law within 24 buous after death. To the Funeral Director: Attenthis certificate hes completely filled in by the funeral director, page 2	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At ho ling, etc. (Specify	ome, farm, str					28f. Location (Stre City or Town,	eet and Numb State)	er or Rura	al Route Number,
_	Hospital	edical C	29a. Certifier 1 XCertifyir (Check only 2 Medical one)	ng Physician: To th Examiner: On the t and man	e best of my know pasis of examinat oner stated.	wtedge, deati tion and/or in	occurred a	at the tim in my op	e, date and inion, deat	d place, a	and due to the cau ed at the time, dat	use(s) and ma se and place, a	nner as s and due t	stated. o the cause(s)
	To the Within To the	Me	29b. Signature and title of certifie	On a	10	1:	29c		number 154049	 }		d. Date signed		
	(0)		30. Name and address of person	who completed cau	se of death (Hem	23a) (Tvbe.	Print)							
			Dr. Reema Ja 31. Date filed (Month, Day, Year,	alali 73	350 VanD	usen R	load #	130,	Laur	rel,	MD 20707	7		
£	Sta Registr		APR 1	2 2006	legistrar's Signal	" A	all!							

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** April 2006 1:00 Marv Lebischak /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9 Bohemia Mill Road Cecil Warwick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 XF 82 Yrs. October 9,1923 221-12-3679 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show nit. Pages t and 2 should be filed within 72 hours after death with the Maryla adment of Idealath and Mantal Hygeins adment of Idealath and Mantal Hygeins returned; or fitem 23a or 28a-f show from it flem 27 is marked other than "natural; or fitems 23a or 28a-f show injury or other traumatic event, the Madical Examinations must be netitied at 1 ☐ Yes 2 X No MD Cecil Warwick Direct 10f. Zip Code 10g. Citizen of Whal Country? 10e. Street and Number 9 Bohemia Mill Road 21912 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specity: White δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pauline Switinski 2 Michael Zaplitney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myron Lebischak/husband 9 Bohemia Mill Road, Warwick, MD 21912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 04-19ate 2006 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. R.T. Foard Funeral Home. P.A. Rising Sun, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sa 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. License 318 George Street, Chesapeake City, MD 21915 23a Fant Enter the disease, or com shock, or heart failure. List only Immediate C = 6 (Final disease or notition resulting is death) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death **Physician** METASTATIC CANCOR /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physicien P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide o the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier C10005656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARTEN 212 DRIVU Covol 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1

DHMH 17 Rev 1/2001

Registrar

2 2006

ORIGINAL

2. Date of Death

Month

3. Time of Death

9. Birthplace (State or Foreign Country) New Jersey

10d. Inside City Limits 1 TYPYes 2 □ No

РМ

	/Medi			Patricia A.	Lawler					April	13	2006	1914 P
	Exami		4a. Facility Name (If not institution, gire	re street and number)		4b. City,	Town, or	Location of	Death		4c. Cour	nty of Death	
			Union Hospital			E1k	cton				Ce	cil	
	Funeral				yrs. last birthday)	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Fore
	Director		169-28-8231	^{1□ M} ² X F 70	Yrs.	World	Days	riouis	TAIRLY.	June 26,	1935	New	Jersey
	2		Usual Residence of Decedent										
4	larylar ehow	_	10a. State 10b. County	100	c. City, Town or Lo	cation						1	10d. Inside City Lin
	9 Ma	cto	Delaware New Cas	stle	New Cas	tle							1 🕅 Yes 2 🗆
0)	11 th	Director	10e. Street and Number			10f. Zip	Code			1	l0g. Citizen o	f What Cou	intry?
_	th wil	aiD	125 Lea Road			19	720				Unite	ed Sta	ites
2	dea	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Vas Deced	ent of Hi	spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)	14. R	ace - Ameri	ican Indian,
_	after after	B	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No					Puerto	Rican, etc.)	В	lack, White,	etc.
	OS ours	b	3 □ Widowed 4 💢 Divorced	If Yes, Give X Year or Dates:		1□Yes 2	X No	Specify:			Spec	illy: Wh	nite
$\overline{}$	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Strier then "natural", or items 23s or 28s-1 ehow ent, it e Medical Extraction must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	lent's Usual	Occupa	ation during most	a fi com alcia		16b. Kind of		
	2 e Fin	gidi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use	e retired))	OI WOIKII.	ig	Garr		
-	21 ad will be set the set of the	lo	10		Sew	ing M	achi	ine Op	erat	or	Manı	ıfactu	ıring
9	oth vent	Be (17. Father's Name (First, Middle, Last	")				18. Mother	's Name	(First, Middle, I	Maiden Sum	ame)	
2	Id build by Itice of the original transfer or the original transfer of the original transfer of the original transfer of the original transfer or	To	Robert Lawler					Не	neri	tte Wol	.fe		
1	Maryland nd 2 should be file the and Mental Hy 27 is marked oth treumatic event		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address	(Street a	and Number	or Rura	Route Number	, City or Tow	n, State, Zij	p Code)
2	Mod 2 alth a 27 tre		Mary Lou Salasl	cv/Daughter	125	Lea R	oad.	New	Cast	le, Del	aware	19720)
34.	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28a-1 ehov any injury or other treumalic event, it a Madical Exemiter must be notified at once.		20a. Method of Disposition	• •	Ob. Place of Dispo				D	ate	20c. Location	n - City or To	
4,	no por por y or		1 🕅 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Speci	Inemoval from State	Woodlawn				-	l 19,	Allent	own,	
	artme		21. Signature of Funeral Service Lice						2006		Pennsy	rivani	.a
	Bal Bal Permi Depa Impo any ii			0 1 ' 1	_ Hi	icks F	Iome	for	Funer	rals, P	.A.		and 21921
			23a, Part1. Enter the disease, or con	onlinations that caused the	doath Do not ont	J3 W.	Sto	ckton	Str	eet, Ell	kton,	Maryla	
_			snock, or neart failure. List only										Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Con	gestive	. He	art	fail	leix	e			years
	/Medical Examiner		resulting in dealiny	a. Due to (or as a cor	nsequence of):	_		10			<u> </u>		,
190		I.	Sequentially list conditions.	b. Chron	ic ob	Ruc	Twe	e pr	en	10 nare	1115	ease	years
/	P 등	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):					•			,
	'60, be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
	0,00,000,000,000,000,000,000,000,000,0		resulting in death) Last	Due to (or as a cor	nsequence of):								
	\$876 icate b	ica		d									
	.O. Box 68760, the death certificate be executed y the attending physician and cohed for use as the burial-transit	hysician/Medicai	IS SEMALE.										
	OX th ce	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pre	9999994				23d. D	ate of delive	ery
	O. B ne deal the att	Cig	in the past 12 months?	4□Pregnant at time		Other (spe					N	fonth	Day Year
	- 0 B		9 Unknown	9□ Unknown									
	Records, P The law requires that ate has been signed t page 2 should be det	by P	Part II. Other significant conditions	A	t resulting in the un	derlying ca	use give	n in Part I.		23e. Did tob	acco use co	ntribute to th	he cause of death?
	rds quire n sig	D D	Diahetes	Mellitus						1 □ Ye	s 2 No	3 🔲 Prot	pably 4 Onknow
	W rac	Completed	Obstant:	Mellitus Sleep	1					24a. Was a	246	More auto	and findings multal
	I Rec The law	ď	- Sieneuve	- egg	J) nue	-				autops	y ned2	prior to con death?	ppsy findings availal impletion of cause of
	E Th									1 ☐ Yes 2	No	1 Yes	2 No
	of Vital Physicien: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			01		of Death	(Check only on	Θ)		
	Of Phys this al dir	ို	1 Yes 2 No		2 ER/Outpatient			4 14013		e 5 Reside			у)
	ding F	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28	c. Injury Work	at ?	2	8d. Describe ho	w injury occu	rred	
	Division of Vital Records, tor Attending Physicien: The law requires taler cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be	cati	2 Accident investigatio			М		es 2□N	0				
	ivi; r Att	THE T	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, stre	et, factory.	office		2	Bf. Location (St. City or Town	reet and Num	ber or Rura	al Route Number,
	Divine or rest after the control of	Certification:		3,						,			
	Divisic Orthe Hospitel or Attentwithin 24 hours after death for the Funerel Director:		29a. Certifier 1 Certifying Pt	nysician: To the best of my	knowledge, death	occurred a	t the time	e, date and	place, ar	nd due to the ca	ause(s) and m	nanner as si	tated.
	the H hin 24 the Fi	Medical	one)	miner: On the basis of exam and manner stated.	illiation and/or inv	estigation, i	n my opi	mion, death	occurre	a at the time, da	ate and place	, and due to) the cause(s)
_	To the Community of the	Σ	29b. Signature and title of certifier			29c.	License	number		25	9d. Date sign	ed (Month,	Day, Year)

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Approximate Interval Between Onset and Death c or respiratory arrest, monary Disease 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No ath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

State Registrar



ORIGINAL

			For State Registrar	State of Marylar	•	artment of H			ene . No 2006	13203
	Physicia		Decedent's Name (First, Middle, IRA ELWOOD	LEWIS, JR.				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death	April 1	8 2006 4c. County of Deat	11:02 p.M
	Examin	ei	Washington Cou	nty_Hospital		Hagers			Washing	ton
	Funeral Director		215-20-9204	1. Sex 7. Age (In yrs. 1. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,) July 12,	'ear) Co	hplace (State or Foreign untry) yland
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	e Mar Ba-f st	ctor	Maryland Frede	erick 1	Myersv			T		1 Tyes 2 No
	th with the 23s or 2 is be no	Funeral Director	13022 Spruce Ru	n Road		10f. Zip Code 21773		100	g. Citizen of What Co USA	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, Ite Medical Examinar must be notified at an ange.		11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? d 1Yes 2XNo If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1☐ Yes 2☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036	vithin 72 hounder.	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of work	ring	6b. Kind of Business/	
	filed w Hygier ther th		6 17. Father's Name (First, Middle, La	ast)	Carpe	enter	18. Mother's Nam	e (First, Middle, Ma	Constructi aiden Sumame)	Lon
/lan	uld be Mental arkad o	To Be	Ira Ellsworth	Lewis			Grace	Mae Mis	ner	
Maryland	d 2 sho		19a. Informant's Name/Relationship C. Christine Lev		1				City or Town, State, 2 lle, Maryl	
	ges 1 ar t of Hea if itam or othar		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Permoval from State	cemetery, cre	osition (Name of matory or other plac	θ)		Oc. Location - City or	
Baltimore,	nit. Pa partmen cortant: injury		* 4 ☐ Donation 5 ☐ Other (Special Service 1)			U.Methodi 2. Name and Addres			arfield, M Main Stree	
ä	Depar Impo any ir		Sall X.	Liekelle					sville, MD	
Ë	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or or shock for heart failure. List or Immediate Seuse (Final disease or condition resulting in death)		c/ewn	ter the mode of dyin				Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	Ical Examiner	Sequentially list conditions, any course to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a consect C. Due to (or as a consect d.						
P.O. Box 68	taw requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	ivery Day Year
	uires that signed b id be deta	by	Part II. Other significant condition Part II. Other significant condition	ellirus						o the cause of death?
Vital Records,		Completed	Chronic Ob	STRUCTIVE Pul.	m c.vanz	Disense) autr	24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	utopsy findings available completion of cause of
/ita	Physician: The this certificate heral director, page	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth		th (Check only one		
of	Physi or this c oral dir	7; To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatie 28b. Time o	of 28c. Injur	4 □ Nursing H	ome 5 Resider 28d. Describe how	ice 6 Other (Spe v injury occurred	cify)
ion	Attending In death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investiga	ation	Injury	M 1	k? Yes 2 □No			
Division of	i Si the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - At h building, etc. (Spec	home, farm, si cify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my kn xaminer: On the basis of examin and manner stated.						
	To the within To the compli	Me	29b. Signature and title of certifier	/		29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
			1/756	- mo		000	53152	4	1. 20 06	2
			30. Name and address of person w	the completed cause of death (Ite	om 23a) (Type	Print) 57	The	rmot 1	10 217	88
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 6 2	maniner: On the basis of examinand manner stated. In the completed cause of death (Itel 2	nature Aca	de		,		

State of Maryland / Department of Health and Mental Hygiene 3204 1 - For State Ragistra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 10, 2006 **Physician** Alfred S. 9:30 A Manasseri /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8610 Snowden River Parkway #119 Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (03/23/1913 (ear) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 577-03-4639 XXXM 2□F 93 Yrs. New York Director Usuel Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ir than "neture!", or itema 23a or 28a-f ahow the Medical Examiner must be indiffed at Columbia 1 Yes 2XNo Maryland Director Howard the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 21045 USA 8610 Snowden River Parkway #119 Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ð If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 12 Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Rosalie Manasseri Samuel Crivallaro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar. Important: If tem 27 te. eny injury or other treusons. 10115 Chickadee Lane Adelphi, Maryland 20783 Rosalie Granata / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 04/12/2006 Clinton, Maryland Resurrection Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 05 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ORUNAR **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). sician and burial-transit death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, certificate hes been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, CONGESTIVE HEART FAILURE 3 Probably Unknown 1 ☐ Yes 2 ☐ No Completed MEULTUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1□ Yes After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of Injury 1 Natural 5 Pending death. 1 ☐ Yes investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the I 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 0 Hospitai 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the h 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie 10,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2465 Route 97 Scott Maurer MD #10 Glenwood, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 2 2006

				;	State of	Marylar	nd / Depa <i>Cei</i>			ealth ar D <i>eath</i>	nd Me	ental H	ygie Reg.	4 U U	6	13	205
			1. Decedent's Name (First, Mid	idie, Last)							1	2. Date of D	eath	Day	Year	3. Tim	e of Death
	Physiciar /Medica		George Anthor	y Mot	sko						A		9,	2006	1001	8:4	O AM
	Examine	-	4a Fecility Name (If not institut						4	b. City, Town		etion of Dea	ith	4c. County			
			National Ins					li lad	- d V	Bethes				Mont			
	Funeral		5. Social Security Number 162–40–1067	6. Sex	7. M 2□ F	Age (In yrs. 59	lest birthday) Yrs.	Months	Days		Min.	B. Date of E (Month, L 03	Day, Yo	er)	9. Birth	place (State)	ate or Foreign
	Director	-	Usuel Residence of Decedent			29						0.5	25	47	reiiii	Sylv	ania
	yland # w		10a. State 10b. Coun	ity		10c. Ci	ty, Town or Lo	cation							1		le City Limits
	Man	ğ	PA			H	onesda	1e								MO.	Yes 2□No
	or 28	Director	10e. Street end Number					10f. Z	p Code				10g	Citizen of V	Whet Cour	ntry?	
	urs efter death with the Marylan al', or items 23a or 28a-f show Examiner must be notified at	a l	2853 Lake Ari	el Hi	ghway				3431					USA			
	tems	nue	11. Marital Status		2. Was Decede Armed Force	es?	I,S. 13.	Was Dece f Yes, sp	edent of H ecify Cuba	ispa <i>n</i> ic Origir n, Mexicen, I	n? (Spec Puerto R	ify Yes or Nican, etc.)	lo-		e - Americ ck, White,		n,
2	s effe	Z Z	1 Never Married 2 M 3 Widowed 4 Divorce		1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes	2 ⋉ No	Specify:				Specify	" Whi	te	
3	72 hours efter death with the Maryland netural', or items 23a or 28s-f show dical Examiner must be notified at	Completed by Funeral		ent's Educa			16e. Dece	dent's Usi	iel Occup	ation			16	b. Kind of Bu			
2	n n n n Medi	bet Bet	(Specify only high Elementary/Secondary (0-12	-	com <i>pleted)</i> College (1-4	or 5+)	(Give	kind of w DO NOT	ork done o use retired	du <i>ring</i> most o i)	of working	9					
Maryland 21213-0020	filed within Hygiene. Wher than " ont, the Mac	Ĕ	Elementary/Secondary (6 12	<u></u>	- 4	0, 0,,	Real	Esta	te Pr	ofesso	or		S	elf Er	nploy	ed	
2	電子 ちき	Be	17. Father's Name (First, Middl	e, Last)										iden Sumam	1 <i>e)</i>		
<u>x</u>		2	Nicholas Mots									Yegli					
g	s mand		19a. Informent's Name/Relatio							and Number				•			
5	an 2 m 2	-	Ginny Motsko	/Wife	2	20h	2853			1 High	nway	, HOD	_	ale, I			
Daiminore,	permit. Pages 1 a Department of Hes Important: If item any Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio		moval from St	***	cometery, crer	natory or	other place		4.	-11-0		Alexar			
	it. Pa ntmer ntant: njury		4 Donation 5 Other			110	•										
0	Depa Impo any l		21. Signature of Funeral Service	20 Licensee	, D	4.0				ss of Facility St. N.							
	11.00	4		Ma	sha										. 0. 2	Approx	
			23a. Part1. Ent rth visease, shock or heart failure. L	ist only one	cause on eac	h line.	III. DO NOT G IN	ei tile ilic	de or dyn	g, such as ca	ardiac or	respiratory	unco	•		Interval	Between and Death
	Physician /Medical		Immediate Ceuse (Final		70.	(T-	-1-0							4	CLALE
	Examiner	- 1	disease or condition resulting in death)	a.	14	Dueto	or as a consec	uence of								7 0	cogs
		ĕ				55010 (0. 40 4 001100	140000.	,.								
	icate be executed physic an and s the burial-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate	6 .	-	Due to (or es e consec	uence of):						i		
00/00	an a	<u> </u>	if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	,													
	ate t	<u>ğ</u>	that initiated events resulting in death) Last	7		Due to (or as a conseq	uence of	:						į		
y	eath certifi attending ; I for use as	S		d													
YOU	atten for u	Physician/M								'- D-41		ook Di	d taba		n tribuuto t	a the cou	use of death?
į	es that the de	S L	Part II. Other significent condi							en in Part I.			Yes				4 Unknow
_	ned b	by P	Lymphon	ratori	y C	ranv	loma	tosis	<u> </u>				_ 103	25010	0	,	
3	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as		/ 3									24a. Wa	as an a	utopsy		ere autor	psy findings rior to
necolds,	s bee	Completed					1.7					Po		.		mpletion death?	of cause
_	The law ate has page 2	E										1	Yes	2LTNo	11	Yes	2 X No
Alta		Bec	25. Was case referred to medi	cal						26. Place o	of Death	(Check onl	one)				
>	S S D		examiner? 1 ☐ Yes 2 No	Ho	spital: 1 Inp	atient 2	ER/Outpatier	nt 3□ C		4 LI Nurs				e 6 □Oth		(y)	
5	ding Ph h. After th funerel		27. Manner of Death Natural 5 ☐ Pen	dina	28a. Date of (Month,	I <i>n</i> jury <i>Dey Year)</i>	28b. Time o Injury		28c. Injur Wor			8d. Describ	e how	injury occur	red		
2	or Attending after death. Director: After in by the fune	Certification:	2 Accident inve 3 Suicide 6 Cou	stigation			1	M		Yes 2 □ No		Of Location	/Stron	et end Numb	or or Pur	of Route	Number
DIVISION	or Att			mined	building	, etc. (Spec	nome, farm, sti <i>fy)</i>	reet, tacto	гу, опісе		20	City or 7			yer or rian	5) 110010	, vallibor,
_1	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	ဒ္ဓ	29a. Certifier Certif	vina Physic	rien. To the h	est of my kn	owledge, deat	n occurre	d at the tir	ne, date and	place ar	nd due to th	ө сан	se(s) end ma	anner as s	teted.	
	To the Hospital within 24 hours and to the Funeral I completely filled	edicai	(Check only 2 Medic	al Examine	er: On the bas and manne	is of examin	ation and/or in	vestigatio	n, in my o	pinion, death	occurre	d et the tim	e, date	and place,	and due t	the cau	ise(s)
	vithin ompl	Ž	29b. Signature and title of certi	fier				2	c. Licens				29d	. Date signe	d (Month,	Day, Ye	ar)
	77 11			de	orte	ليالا	mo		D	0063	37:	2	1	pril	9.	200	6
,	10	1	30. Name and address of person	who com	pleted cause	of death (Ite	m 23a) (Type,	Print)						/			
	SC		CHIA POR	TER.	A . ^	11)	1	O Cei	nter	Drive,	Bet	thesda	a, 1	Maryla	ind 2	0892	
	State	, 1	31. Date filed (Month, Day, Ye	ar)	32. Reg	istrar's Sign	ature										

DHMH 16 Rev 6/95

		State of Maryland / Department of Health and M 1 - For State Registrar Certificate of Death		iene 0 0 6	13206
Physic	ian	Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death
/Med		Roberta Whitaker Miller 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	April 8	8, 2006 4c. County of Dea	6:00P M
Exami	ner	Arcola Health & Rehabilitation Center Silver Spring		Montgom	
Funera Directo		5. Social Security Number 6. Sex 1 Months 1 Mont	8. Date of Birth (Month, Day, Februa)	9. Bir ry 13, 1913	thplace (State or Foreign ountry) Ohio
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	-		10d. Inside City Limits
Maryl.	ŏ	MD Anne Arundel Odenton			1 Yes 2 No
r 28a	irec	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
th with	ai D	1023 New Dawn Lane 21113		USA	
urs after deal	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
ESITIMOFE, IMBITYIBING ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction armist the notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during most of workiii life. DO NOT use retired) Book Keeper	ng	16b. Kind of Business Anne Arun School Di	del County
VIANG A	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	ence Ric		
Mar d 2 sho th and 7 is my traumy		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rura</i> Robert J. Miller/ Son 1023 New Dawn Lane Od	enton. 1	-	Zip Code)
ore, less 1 and of Heal		Robert of Hiller, bon 1020 How 1020		20c. Location - City of	Town, State
SCILLIMOR Dermit. Pages Department of I	1	4 Donation 5 Other (Specify) Huntt Crematory 4/11	/2006	Waldorf,	
Dermit Depart Impor		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rob 16000 Annapolis Ro	ert E. I	Evans Fune ie, MD 20	ral Home 715
Physiciar		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis	or respiratory arr	est.	Approximate Interval Between Onset and Death Days
icate be executed physician and physician and surial-transit sine burial-transit	Icai Examiner	Sequentially list conditions, if any, beading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Urinary Tract Infection Due to (or as a consequence of): Constitution of the consequence of consequ			Days
Geath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		23d. Date of de Month	olivery Day Year
COLDS, P. wrequires that s been signed by should be deta	र्व	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperthyroidism		bacco use contribute t es 2 □ No 3 □ F	o the cause of death?
The la	Completed	Diverticulosis	24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of s 2 \(\subsection \) No
VITAI sician: T certificat irector, pa	Be	25. Was case reterred to medical examiner?			
Of N Physi r this c	7	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 X Nursing Hot 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (Speom ow injury occurred	ecify)
ding P. After tuner	tion	27. Manner of Death 1 Naturat 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Accident investigation	200. 2000.120 11.	ow injury coodings	
Atten deat deat ctor: y the	Certification:	2 Transaction	28f. Location (S City or Town	treet and Number or F n, State)	lural Route Number,
DIV To the Hospital or v within 24 hours after To the Funsral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.			
To the within 2 To the complet	Mec	29b. Signature) and title of certifier 29c. License number	2	29d. Date signed (Mon	th. Day, Year)
3 = 0		D-32332	A	April 10, 2	2006
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	G.11		20002
		Suresh Kumar Gupta, MD 9801 Georgia Ave Suite #220 S	Silver S	opring, MD	20902
S Regis	tate strar	APR 1 1 2006			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 2006 7, **Physician** 8:40 P M Margaret Audine McMichael /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LaCasa LLC Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Days Hours Min Ohio 1 □ M 2 😿 F 103 Yrs. 1902 557-64-3882 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a, State 10c. City, Town or Location or 28a-f show Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Heath and Mental Hygiene. and the Table at a marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, It a Medical Examinat must be a willish at 1 ☐ Yes 2 XNo Director Maryland Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 9 Sonneborn Lane United States Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 □ Yes 2 🕅 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 X No Specify. Baltimore, Maryland 21215-0036 3 X Widowed 4 ☐ Divorced 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) County Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George W. Allen Della A. Dempsey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Severna Park, Maryland 21146 George L. McMichael / Son Sonneborn Lane 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Forest Lawn Cemetery 4/20/2006 Glendale, California 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice John M. Taylor Funeral Home, Annapolis, MD 21401 147 Duke of Gloucester St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIMEI **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner NEUMONIA The law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as the t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ò in the past 12 months? Month Day 5 Other (specify) 1 Yes Division of Vital Records, P.O. detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No certificate has 1 ☐ Yes 2 ☐ No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes _ 2 No this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti 5 Pending investigation XX Natural 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mille 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 122 De MARIA RONERO M.D ense in 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2006 Registrar

Amend item#22, perFH, 854, 4/2//00 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:25 AM 17 Connie Marie Mose April 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Broadmore 1175 Professional Ct. Assisted Living

Assisted Living

If Under 1 Year If Under 24 Hrs.

Win last hirthday) If Under 1 Year If Under 24 Hrs. Washington County Hagerstown 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 XF 77 Director 213-24-9018 January 20-1929 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at X Yes 2 □ No Maryland Directo Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1175 Professional Court 21742 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within hent of Health and Mental Hygiene. int: If item 27 le marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Teller Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Paul Lewis Palmer Alice Marie Good Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17225 Susan V. Hawbaker (daughter) 12253 Coll Hollow Rd. Greencastle Pennsylvaniz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Conation 5 Other (Specify) permit. Pages Department of Importent: If it eny injury or c 4-20-2006 Hagerstown Maryland Rest Haven Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. 1331 Eastern Blvd. W. Hagerstown, MD 21742 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 00 months Sma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 @ ni 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 200 1 ☐ Yes Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 046473 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vaar **Physician** 12:55PM Apri1 10,2006 Theresa Maskee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months 066-20-5424 93 20,1912 New York Director November Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits 10h County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director Harford Bel Air 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 111 Canvas Place 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify White δ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed withi and Mental Hygiene. Production Worker Tire Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peter Lizak Mary Lizak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: if Item 27 is Carol Brubaker/daughter 111 Canvas Place, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gar. 4/13/06 Leonardtown.MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00945 AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequent of): Examiner that initiated events resulting in death) Last Due to (or as a conseque of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 22 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one)

Maske, Lear #800 23476

After this certificate has been signed by the attending physicien and tuneral director, page 2 should be detached for use as the burial-transit

Certification: To

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and Ritle of certifier

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

neral Director: A within 24 hours 6 To the Funeral C o the Hospital

1 16

State Registrar

APR 1

2 2006

5 Pending

investigation 6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 XInpatient

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

(north)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

04-11-2006

DHMH 17 Rev 1/2001

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

500 40

06-02516 UNK UNK			Ctata at				Black Ind		luminum			
ED MOLLI	5	1- For State	State of	iviaryiar		rtment o tificate o		nd Mental I	Hygiene		2006	13216
Physicia		Registrar 1. Decedent's Name (First, M	iddle.Last)	_		incate o	Death		2. Date of D	Reg. No.	2000	3. Time of Death
Medical Exami		Leo Anth		Morris					Month April 13,	Day	Year	0455 hrs
		4a. Facility Name (if not instit			ber)		4b. City, Town,	or Location of Dea			c. County of Death	
{		315 Bethune Aven	ie				Hagerstov	/n		V	Vashington	
Funeral		5. Social Security Number	6. Sex	7	. Age (In yrs. la	ast birthday)	If Under 1 Ye Months Da		Irs. 8. Date of in.	Birth (MM)	(DD/YYYY) 9. Birt Foreig	
Director		235-11-3404	1 X M	2F	31	Yr		lys Hours IV	" Apri	1 1,3		untry) WV
ý.		Usual Residence of Deceder 10a. State 10b. Cou			10c City	Town or Loca	tion					10d. Inside City Limits
00 ar			ferso	-		son	NOT					1 X Yes 2 No
ryland a-f sh t once	ctor	10e. Street and Number	Tersoi	LI	Nai	ISON	10f. Zip Code			10a Citi	zen of What Cour	
or 28	Jire	340 E. 11th A	we. Ai	nt #40°	3		25438			US		,
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	11. Marital Status		-	dent Ever in U.	S. 13. W		hspanic Origin? (Specify Yes or I		14 Race - Ameri	can Indian, Black,
leath r	nue	1 XXNever Married 2	Married	Armed Ford	ces? 2XX No	lf`	Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		White, etc.	
after c		3 Widowed 4	Divorced If	Yes, Give Year	- <u>4.22</u> ,£110	1	Yes 2 X N	o specify:			Specify: Blad	ck
nours	Completed by	15. Decedent's Education (' '			ation (Give kind of fe. DO NOT use re		16b. I	Kind of Business/l	ndustry
16 n 72 h nan "r ical E	olet	Elementary/Secondary (0-	12)	College (1-4	1 or 5+)	_						
withi withi giene her th	шо	12 17. Father's Name (First, Mic	dle (ast)			Packe	r/Loadeı	Mover 18.Mother's Nar	ne (Firet Middle			Moving Co.
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	BeC	Maurice Togar							,		,	
212 ould by Ment mark	TO E	19a. Informant's Name/Relati	onship (Type	e, Print)		19b. Mailin	ng Address (Str	eet and Num er o	r Rural Route N	umber, C	Woodson ity or Town, State	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Mildred Ann M	orris			204	S. Marsh	nall St.	Ranso	a. W	7 25438	
re, l l and l'Heal		20a. Method of Disposition 1 Burial 2 XX Crema	tion 3	Removal from			sition (Name of c		Date		Location - City or	Town, State
Pages sent of		4 Donation 5 Othe		Nemoval non		thsbur	cremat	orium 04	4/19/200	OA Sn	nithsburg	MD
salti rmit. epartn nports jury e	1	21. Signature of Funeral Ser	rice Licensee	e		22.	Name and Addre	ee of Eacility			el Funer	7
		23a. Part I. Enter the disesse	Drow	un			PO Box	- 838 C	erles i	Criar Cown .	7.7.7.2541	at nome
Physician /Medical		23a. Part I. Enter the dis 3 se failure List only one ca	use on each	line.			the more of dyin	Such is Carnet	OF RESIDENTIAL .	Brust, She	bck, he	Between Onset and
Examiner	1) /3	Immediate Cause (Final dise or condition resulting in deat			p force inju							Death
			• и b.	e to (or as a c	consequence of	r):						
	Jer	Sequentially list conditions, if any, leading to immediate	Due	e to (or as a c	onsequence o	F):			-		-	
<i>t</i>	Examine	cause Enter Underlying Ca (Disease or injury that initiate	ed ^{C.} —	e to (or as a c	onsequence of	F\·						
V uted Idea	EX	events resulting in death) La	d d	0 10 (0) 40 4 0	0,100 440 1100 0	.,						
e executed sian and ial - transi	dical	UNPENDED		AMENDED								
(ecords, P.O. Box 68760, The law requires that the death certificate be executed at the abeen signed by the attending physician and agge 2 should be detached for use as the burial - transit	Mec	IF FEMALE:		23c. If yes, ou	tcome of preg	nancy				23	d. Date of delivery	
Box 68760 e death certificate be the attending physical for use as the but	sician/Me	23b. Was decedent pregnant past 12 months?		1 Live birt	th nt at time of de	oth _	etal death 3	Ectopic preg	nancy		Month D	ay Year
Sox leath e atter for ur	ysic	1 Yes 2 No 9	Unknown	9 Unknow		atin 5 0	ther (Specify)					
that the d ned by the detached	Phy	Part II. Other significant co	nditions co	ontributing to o	death but not re	esulting in the	underlying cause	given in Part I.	23e. Dio	tobacco	use contribute to	he cause of death?
s, P.O. ires that the r signed by I	d by								1 🗆 ነ	es 2	No 3 Prob	ably 4 🗸 Unknown
ords, w requir	Completed								24a. Wa	s an opsy		opsy findings available ompletion of cause of
eco ne law te has	щ									formed?	death?	_
riffica or, pa	ပိ	25. Was case referred to me	dical				26.Pla	ce of Death (Chec		,	- T	2 110
Vita ysicia his ce direct	o B	examiner? 1 ✓ Yes 2 No	Hos	pital: 1 🔲 Inp	patient 2	ER/Outpatien	t 3 DOA	Other Nurs	sing Hame 5	Reside	ence 6 🗸 Other	Scene
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	n: T	27 Manner of Death		28a Date of	f Injury Day,Year)	28b. Time of	Injury 28c. In	jury at Work?	28d. Describ Subject st			
Division of Vital Records, rat or Attending Physician: The law requints after death al Director: After this certificate has been siled in by the funeral director, page 2 should the	atio		ending nvestigation	Apr 13, 20		FOUND: 0450 hrs	1	Yes 2 V No	Subject st	anneu (and cut	
ivis or At after d Direc	tific	3 Suicide 6	could not be	28e. Place	of Injury - At ho	ome, farm, stre	et, factory, office	building, etc.	28f. Location or Town		and Number or Ru	al Route Number, City
Division ospital or Attend hours after death meral Director:	Certification:	4 Momicide	letermined	(Specify)	Found outs	ide dwellir	ng				, Hagerstown	, MD
王 24 王 15											id manner as start ace, and due to the	
To the within To the comple	Medical	29b. Signature and title of ce	ar	nd manner sta	ited.			nse number			Date signed (Mor	
	-	200. Orginators and the of ce	111	70.	/			M.E.			il 13, 2006	ur, Day, Tear)
		1 herohe	1.	anleted of	un	220)				, (pi	10, 2000	
		30. Name and address of per Theodore King MD			of death (Item al Examine	•	enn Street, B	altimore, MD	21201			
· Si	ate	31. Date filed (Month, Day, Ye	ar)		istrar's Şignatı	ITO A						
Regist		APR 2 6	2006	Hadres.	, St.	Goarle						
					•							

		-	State of Maryland / Depa 1 - State Registrer Cer	rtment of Health and Men	ntal Hygiene	UUU IJAII
			Decedent's Name (First, Middle, Last)		Date of Death Month Day	3. Time of Death
	Physici: /Medic		EMILIO DE JESUS MIRANDA		RIL 13,	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death
			WALDORF HEALTHCARE	WALDORF		CHARLES
	Funeral Director	121	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1216-39-4747 79 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year)	
	and *	}	Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "naturel; or Items 23a or 28e-1 show other traumatic event, the Practical Exactlinating the notified at	ō		DORF		1 ☐ Yes 2X
	28e	Director	MARYLAND CHARLES WAL	10f. Zip Code	10g. Cit	izen of What Country?
	3a or		4140 OLD WASHINGTON ROAD	20602		U.S.A.
	death ms 2	Jere		Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - American Indian, Black, White, etc.
ဖွ	after or its	by Funerai	1 ☐ Never Married 2/27 Married 1 ☐ Yes 3/27 No	☐ Yes 2 No Specify:	11, 010.)	Specify: FILIPINO
ဗ္ဗ	urel',		3 Wildowed 4 Divorced Year or Dates:			
21215-0036	"natt	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. K	ind of Business/Industry
12	withing the state of the state	dm	Elementary/Secondary (0-12) College (1-4or 5+)	·		ANNER GUARG
2	filed Hygle		17. Father's Name (First, Middle, Last)	MECHANIC 18. Mother's Name (Fit		CHANIC SHOPS Sumame)
Maryland	ld be Red o	To Be	EMILIO MIRANDA	UNKN	OWN	
<u></u>	2 shoul and Me Is marl sumeti	F		g Address (Street and Number or Rural Ro	oute Number, City o	or Town, State, Zip Code)
	nd 2 alth al 27 Is	1	ANGELINA MIRANDA-DAUGHTER 8319	LONGFELLOW ST.,	NEW CAR	ROLLTON, MD20784
Baltimore,	s 1 al f Hea item othe		20a. Method of Disposition 20b. Place of Disposition			ocation - City or Town, State
Ë	permit. Pages Department of I Importent: If it any injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) METROPOLITIAN	, , ,	·06 ALE	CXANDRIA, VA
ä	mit.	l	21. Signature of Fundral Service Licensee MOO47 22	Name and Address of Facility AYMOND FUNERAL S	EDVICE.	D 7
m	Depa Depa Impo any in			A PLATA, MARYLAN		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Fnysician			hephalogatuy		Onset and Death
	/Medical					
	Examiner			ake		
	₽ ₩	iner	if any, leading to immediate	a Code La crea		
V	and trans	Examine	Cause (Disease or injury that initiated avents resulting in death) Last Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as a cogsequence of):	friciency		
90,	te be executed ysician and ie burial-transit	E	A. Fib.			
68760	± × ±	edical	d			
9 ×	death certifica e attending ph od for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atten for u	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month Day Year
o.	at the de by the a tached t	ysic	1 Yes 2 No 9 Unknown			
Δ.	g g g		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds,	uires signe	d by			1 🗌 Yes 2	No 3 Probably 4 □Unknown
Record	w requ	Completed			24a. Was an	24b. Were autopsy findings available
Re	The law ate has page 2	mc			autopsy performed?	prior to completion of cause of death?
Vital		Ö	25. Was case referred to medical	26, Place of Death (C	1 ☐ Yes 2 X No	10163 2010
>	Physicien: r this certific ral director,	o B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing Home	5 Residence	6 □Other (Specify)
Jo L	g Ph er thi	Ë	27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury		. Describe how inju	
jo	Attending I or death. ector: After by the funer	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	after de Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	eet, factory, office 28f.	Location (Street at City or Town, State	nd Number or Rural Route Number, e)
	rs after or rs after or rel Dir	Cer				
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only (Ch	vestigation, in my opinion, death occurred a	at the time, date an	d place, and due to the cause(s)
	To the within 2 To the Complet	Med	one) and manner stated.	29c. License number	29d Da	ate signed (Month, Day, Year)
	To To		M M	DAN 57999	4	-117/06
,			The second secon	Orint)	1-0 1	11 4 100 20602
	1		29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, MAN ISHA JARIWALA MD 11657	Terrace Prive, Ste	103, Wa	bant, MID 2002
	St	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
	Regist		APR 2 6 2006	we want		

			1 - For State Registrar	State of	Maryland		artment o			nd Mental I	lygie:	$Z \cup U$	06	13213
	Physici	an	Decedent's Name (First, Middle							2. Date of Month		Dav	Year	3. Time of Death
	/Medic		Katrina R.	Miller						Apr			2006	12:51PM
	Examir	er	4a. Facility Name (If not institution,	3	•	•	4b. City, Tov			Death			nty of Death	
			Southern Mar 5. Social Security Number		. Age (In yrs. la		If Under 1 Y	int	On If Under 24	Hrs 0 Data of				eorges
1	Funeral Director		213-86-7935	1 ☐ M 2 🕮 F		36 Yrs.			Hours	Min. 8. Date of (Month) June	Day, Ye	ar)		ace (State or Foreign
			Usual Residence of Decedent			J. C.				Julie	1/	, 19	OB Wa	sh.,DC
	how	_	10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside City Limits
	Ba-f	cto	MD. P	G	Ca	pito.	1 Heig		S.					1 ☑ Yes 2 ☐ No
	with the	Dire	10e. Street and Number				10f. Zip Co						of What Count	,
	eath	erai	6864 Walker	MILL RO. 12. Was Deced		2 13 1		743	ania Osinia	-2 (Casaita Van			d Sta	
′0	fter d	Funeral Director	1 Never Married 2 Marrie	Armed Ford	es?	3.	Yes, specify	Cuban, I	Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	NO-		ace - America lack, White, e	
036	el. o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dat			☐ Yes 2🔯	No S	Specify:			Spec	Bla	Ck ·
5-0036	n 72 hours after death with the Maryland "neturel", or iteme 23a or 28a-f ehow edical Exeminer must be notilited at	Completed	15. Decedent' (Specify only highes	s Education		16a. Deced	lent's Usual O	ccupatio	on ring most o	af working	16b.	Kind of	Business/Ind	
21	- 10	mpie	Elementary/Secondary (0-12)	College (1-4	for 5+)	life. L	OO NOT use re	etired)	mg most o	. Working				
121	filed w Hygiei other ti		1.7. Father's Name (First, Middle, L	acti		S	ecret			Alama (Pitan Adia				Store
Maryland	S = 20 >	Be		,						Name (First, Mio		en Sum	ame)	
Z	should bind Ment	မှ	James Short 19a. Informant's Name/Relationsh			19h Mailin	n Address /St			r Fisher		v or Tou	m State Zin	Code
<u>≅</u>	nd 2 sho lith and 27 is m		Joan A. Short			1010	8 Go1	dfi	nch	Souzt7	niber, cit	y 0/ 10 m	ri, State, Zip	2009)
ē,	is 1 and of Health item 27 other tr		20a. Method of Disposition	, , , , , , , , , , , , , , , , , , ,	20b. Pla	ace of Dispo:	sition (Name o	of	VIar	Date	20c.	Location	n - City or Tov	vn, State
e E	Pages ent of nt: If it		1 ♣ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				atory or other ction		m . 4	1/28/06	C1	int.	on, M	D.
Baltimore,	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service L							Hodges			-	
œ	Depermine Depe		Annee ?	Edeva	de					_				D.20746
	. 6 .		23a. Part1. Enter the disease, or o	complications that car	used the death.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Sin	m	-							Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	as a conseque	ence of):			*					- no-my
4	CAGIIIII EI		Sequentially list conditions,	b	Source	7 14	y rest	Ton	SON	/			6	nknown
V	lsit ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	as a consequ	or co ory.	7							
. 4	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of);							_	
8760	The law requires that the death certificate be executed to has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit.													
9	of the	Physician/Medical		d.										
Вох	eath certific et ending pl for use as f	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			F-Ai					23d. E	ate of deliver	y
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ∏ Fetal on tat time of dea		Ectopic pregna Other (specif)				_	N	fonth [Day Year
P.0	that the de led by the c	hy	9 Unknown											
	res tha iigned be det		Part II. Other significant condition	_	1 1		derlying cause	e given i	in Part I.					cause of death?
oro	v requir been si should	ted	Milles/ens/a	e Enley	or new	pury				_ 1	Yes	2 ∐ No	3 Proba	bly 4 Laknown
Vital Records,	e law has b	Completed by								24a. W	topsy		prior to com	sy findings available pletion of cause of
a										1 ☐ Ye	rformed?		death? 1 ☐ Yes 2	ID No
Κ		Be	25. Was case referred to medical examiner?	Hospital:				04		Death Check on				
o	Phys r this ral di	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	- Inp		PVOutpatient 28b. Time of				ng Home 5 ☐ R				
O	ding th. th. After funer	ţ	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury		Injury at Work? 1 ☐ Yes	s 2∐No			in a coco	11160	(
Division	f or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could no	286. Place 0	Injury - At hon	ne, farm, stre	et, factory, off	fice		28f. Location	(Street	and Nun	nber or Rural	Route Number,
ā	s afte	Certification:	4 Homicide	building	, etc. (Specify)					City or	Town, Sta	ite)		
	To the Hospital or Attentwithin 24 hours after dealt To the Funeral Director: completely filled in by the		29a. Certifier 1 Dertifying	Physician: To the b	est of my know	rledge, death	occurred at th	he time,	date and p	place, and due to t	ne cause	(s) and n	nanner as sta	ted.
	the H in 24 the F iplete	ledical	one,	and manne	r stated.					occurred at the tin	e, date a	nd place	, and due to t	ne cause(s)
	To To	Σ	29b. Signature and title of certifler	1/2)			29c. Lic	cense nu	umber		29d. C	ate sign	ed (Month, D	ay, Year)
•	/		1 pm/	1 d			50	42	4		46	us)	181	06.
	5	d	3 1 /	no completed cause	of death (Item :	23a) (Type, F	Print)	001		N 20-			,	I
55	Sta		31. Date filed (Month, Day, Year)	Ja. Bar	S-35%	ne ?	100001	pall	71	5905 an				
	Registr	-		006	K	Good	E.B.							
			11111 W L	ALTERNATION OF	U -	2								

			T = For State Registrar	State of Maryland		rtment of			gienę Reg. No.	006	13211
			Decedent's Name (First, Middle, Last)					2. Date of De		Yeer	3. Time of Death
	Physici: /Medic		Helene M	Neal				April	5	2004	21:54 M
)	Examin	er	4a Facility Name (If not institution, give sti	1 . 1. 1	1/autor	4b. City, Town	or Location of Dea	th	4c.	County of Death	cup dal
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Is	est birthday)	If Under 1 Yea		8. Date of Bir	th Veac	9. Birth	place (State or Foreign
	Director		FIG 17 (1710)	M 200 F	Yrs.	Months Day	s Hours Min	8. Date of Bir (Month, Da	4,19	24 G	ermany
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation					10d. Inside City Limits
	Mary III	tor	MD Anne Arui	ndel	0dento	n					1 ☐ Yes 2√TNo
	death with the Maryland rms 23a or 28a-1 show	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	sath w		1129 Colony Ridge	Road 2. Was Decedent Ever in U.S	3 13 V	Vas Decedent o		Specify Yes or No		USA 14. Race - Ameri	can Indian
0	r Item piner	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No			I Hispanic Origin? (Suban, Mexican, Puer	to Rican, etc.)		Black, White	etc.
5-0036	I within 72 hours after death with the Marylan ilene. I then "natural", or Items 23a or 28a-1 show The Madical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		☐Yes 2 X N	lo Specify:				nite
7	"natu	Completed	15. Decedent's Educa (Specify only highest grade		(Give)	lent's Usual Occ kind of work dor DO NOT use reti	ne during most of wo	orking	16b. Kir	nd of Business/Ir	ndustry
717	s within glene. r than the Max	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Homem	aker			Ow	n Home	
and	be filed Ital Hygi Id other	BeC	17. Father's Name (First, Middle, Last)	- J				me (First, Middle		Sumame)	
5		2	Nikola Kalaschniko		405 44-10-	- Add (Ca-		ete Best		Town State 7	- Codel
Z Z	C/ 42 75 42	1	19a. Informant's Name/Relationship (Typ Harry Neal (Son)	e, Phint)			et and Number or A rt Avenue				p C009)
ē,	Heg The		20a. Method of Disposition	20b. Pl		sition (Name of natory or other p		Date		cation - City or T	own, State
Ē	Pages ment of ant: If it ury or o		1 X Davial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		Nat. C	1	3-2006	Ar1	ington,	VA
Baltimore,	permit. Pag Depertment Important: I any injury o once.		21. Signatine of Funeral Service Oceases		22	Name and Add Hardes	_{dress of Facility} ty Funera gely Aven	1 Home,	P.A.	e MD 2	1401
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	. Do not ente					3 FID 2.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Coronary	Acto	ery D	ispase	_			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	ence of):						J
	à	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a consequ	ience ol):	Or I					
	ocuted nd transit	Examiner	that initiated events C.								
60,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a consequ	ience ol):						
09/89	ate the	edicai	d.								
XOA	eath certific attending p for use as	M/us	230. was decedent pregnant	ic. If yes, outcome of pregnat 1□Live birth 2□Fetal		Ectopic pregna	ncv		2	23d. Date of deliv	•
о Э	the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (specify)				Month	Day Year
٦.	The law requires that the de ste has been signed by the a bage 2 should be detached t		Part II. Other significant conditions cont	ributing to death but not resu	Ilting in the ur	nderlying cause	given in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
Vital Records,	quires n sign uld be	d by						1 🗆	Yes 2	No 3□Pro	bably 4 Unknown
000	e law require has been sig ge 2 should b	Completed						24a. Was		24b. Were aut	opsy findings available ompletion of cause of
ř		Com						perfe 1 ☐ Yes	ormed? 2. No	death? 1 ☐ Yes	2 % No
ŽĮ	tending Physician: The leath. tor: Atter this certificate hatter this certificate hatte funeral director, page	Be	25. Was case referred to medical examiner?	ospital:			Othor	eath (Check only			
	Phys arthis eral di	2	27. Manner ol Death	28a. Date of Injury	ER/Outpatien 28b. Time of	1 3 DOA	4 ☐ Nursing njury at Vork?	Home 5 ☐ Res 28d. Describe			ify)
Ö	ittending I death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Vork? ☐ Yes 2 ☐ No				
Division of	or At	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, larm, str	eet, factory, office	СӨ	281. Location (City or To			ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificic completely filled in by the funeral director.	edical C	29a. Certifier Certifying Physic (Check only one)	ician: To the best of my knower: On the basis of examination and manner stated.	wledge, death ion and/or in	n occurred at the vestigation, in m	time, date and place y opinion, death occ	e, and due to the curred at the time.	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	0 -		29c. Lice	ense number		29d. Dat	e signed (Month	Day, Year)
			Edith Kayfre	Id, MD		DO	06292	5	APR	sil los	2006
			30. Name and address of person who con	mpleted cause of death (Item	23а) (Туре,	Print) Pr	ad #107	Odento	m 1	nd 2	1112
	Sta	ate	31. Date filed (Month, Day, Year)	32. egistrar's Signa		2011 - NU	NU # 10 1	Cae III	JI LCT		٠٠١ ح
	Regist		APR 1 1 20	06	T 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Ivialyta
State Registrar AACO Health Dept. 4/11/06 orth Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2 Date of Death 3. Time of Death **Physician** heresa NIZER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner len Burne Van If Onder 24 Hrs. ANNE Arundol Nov7/ And ARUNDER HOSPITAL 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ 212-80-8685 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or iteme 23a or 28a-f ehow other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director BNNE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4-5. 13. Was Decedent of Hispanic Oligin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ∑ No If Yes. Give Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1□ Yes 2□ No Specify Specify: Black 3 Widowed 4 Divorced "neturel". Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "ne eny injury or other treumatic event, the Mudic 2002e. Elementary/Secondary (0-12) College (1-4or 5+) Home Health Private Family 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Warren Clagget Virginia Brown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Nizer(Husband) 1721 Meade Circle Rd. Severn, Md. 21144 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Bearing) acts 1 Date 20c. Location - City or Town, State 4-13-06 Annapolis, Md. 4 □ Donation 5 □ Other (Specify) Park 21. Signature of Funeral Service Licenses Wm. Reese & Sons Mortuary, P.A. MO0485 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ervica /Medical Due to (or as a consequence of) Examiner Sequentially list on differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit nding physicien and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an 245. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No performed 1 Yes 22 No efter death.

| Director: After this certification of the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records. To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by it

heresq

State Registrar

Medicai

29a. Certifier

31. Date filed (Month, Day, Year)

Vivian

29b. Signature and title of certified

raca TREE . Registrar's Signature

and manner stated.

MOSE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicare Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year,

		1 - For State Registrar	State of Marylan	•	artment of F			iene 19. No. 006	13216	
Physi		1. Decedent's Name (First, Middle, Las	0. Nob	10			2. Date of Deat Month	Day Year	3. Time of Death	
/Med Exam		4a. Facility Name (If not institution, give Prince George's	4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince George's				
Funera Directo		5. Social Security Number 6. So 266-75-4851 1		last birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb. 3,	Yearlo 9. Birti	hplace (State or Foreign untry) Lippines	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23s or 28e-f show eny injuryor gother traumatic event, the Medical Evandran must be notified at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Adelphi 10de City Limits								
	i Director	10e. Street and Number 7911 24th Place			10f. Zip Code 20783			0g. Citizen of What Country? USA		
rs after deeth	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: Asia	e, etc.	
d within 72 hours afgione. gione arthan "neturel", or	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hotel Clerk			16b. Kind of Business/Industry Hote1		
Maryland A d 2 should be filed v th and Mental Hygie ty is marked other t traumatic event, III	To Be Co	17. Father's Name (First, Middle, Last) Raymundo Obinario			18. Mother's Name (First, Middle, Ma.) Unknown					
INGI Y		19a. Informant's Name/Relationship (Type, Print) Flora Jose/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City 7911 24th Avenue, Adelphi, Mary)								
baltimore, bermit. Pages 1 er Depertment of Hee Importent: if item;		20a. Method of Disposition 15€38urial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emetery, cren	sition (Name of natory or other place even Cemete		12,	20c. Location - City or ilver Spri	Town, State	
permit. Depertm Imports ony inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901								
To Attanding Physicien: The law requires that the death certificate be executed of the factor. The law requires that the death certificate be executed of the cash. Director: After this certificate has been signed by the ettending physicien and in point in by the funeral director, page 2 should be detached for use as the burial-transit on point in by the funeral director.	i	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, br heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1					23d. Date of del	23d. Date of delivery Month Day Year	
	۾						cco use contribute to the cause of death? 2,№ No 3 □ Probably 4 □Unknown			
	Completed						24a. Was an autops perform	prior to death?	itopsy findings available completion of cause of 2 No	
sicien: The sicien: The sicient of t	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
VISION OF VICES Attending Physicien: r death. ector: After this certifice by the funeral director, f	 -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?			28d. Describe how injury occurred				
tal or Attencts after death of Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by	ledicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the To the To the Comp	Me	29b. Signature and title of certifier Karen R Brooks			29c. License number 25			9d. Date signed (Month, Day, Year) 4-11-06		
		30. Name and address of person who Karen R. Brooks				Clinton	MD 2073	5		
S Regis	State	31. Date filed (Month, Day, Year)	32. Signa 32. Signa		and i					

		For State Registrar	State of Ma	ryland .	•	irtment of t tificate of		Mental Hyg	iene	16	13217
Physici		1. Decedent's Name (First, Middle, Las Zella Lorraine N						2. Date of Deat	Day -	XYear G	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give					or Location of Dea	ath	4c. Count	ty of Death	
		Washington County 5. Social Security Number 6. Se		(In yrs. last	birthday)	Hage	rstown	s. 8. Date of Birth	1	ingto	on place (State or Foreign
Funeral Director		219-12-2425	□M 2 ⊠ F	86	Yrs.	Months Days	Hours Min	Feb. 5,	1920	Cou	and
yland yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
ne Mar 8a-1 el	ector	Maryland Washing	ton	Hage	ersto						1 ☐ Yes 2 ☒ No
3a or 2	i Dir	10e. Street and Number 115 North Locus	t Street			10f. Zip Code 2174	0	1	0g. Citizen of USA	What Cou	ntry ?
and 2 should be filled within 72 hours after death with the Maryland Health and Mental Hygiene. If health and Mental Hygiene. Other traumatic event, the Medical Examination of citied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Vas Decedent of I Yes, specify Cul		Specify Yes or No- irto Rican, etc.)		ack, White,	can Indian, etc. hite
"natur	Completed	15. Decedent's Ed (Specify only highest gra		1	(Give	lent's Usual Occu kind of work done OO NOT use retin	during most of we	orking	16b. Kind of 8	Business/Ir	ndustry
withir jiene rithen	ошо	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ary aide			hospi	tal	
or of the traumatic event, I a Mill to the traumatic event, I a Mi	Be	17. Father's Name (First, Middle, Last)	a h a su					ame <i>(First, Middle, F</i> Barbara E		,	
should bd Men marke matic	7	John Dickson Swi			19b. Mailin	g Address (Stree		Rural Route Number			o Code)
1 and 2: Health ar		Joyce Hines - da				·	Terrace,	Hagersto			
		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cem	etery, cren	sition (Name of natory or other pla n Mem. I		Date -8/06	20c. Location Hagers		own, State , Maryland
permit. Page Department of Important: If ony injury or		21. Signature of Faneral Service Licen		- ^		. Name and Addr		MINNICH I			
3 445 3		23a. Part1. Enter the disease, or comp	plications that caused	the death				l., Hagers		Md. 2	21740 Approximate
Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	· Cn	en'	monic	۸.				Interval Between Onset and Death
Examiner		Sequentially list conditions	b.	Consequen) W/ n	nonar	1 Fi	brosi	S		
led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	ice of):						
an and	Exar	that initiated events resulting in death) Last	cDue to (or as a	consequen	ice of):						
cate be physici the bu	edical		d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brous after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 🗌 Fetal de	ath 3	Ectopic pregnand			1	ate of deliv	ery Day Year
uires that signed to	by	Part II. Other significant conditions co	ontributing to death bu	it not resultin	ng in the ur	nderlying cause g	iven in Part I.		oacco use con es 2□No	ntribute to t	the cause of death?
law rec as beer 2 shou	Completed							24a. Was a		. Were auto	opsy findings available
: The cate har, page								perform		death?	
siclen s certifi	To Be	25. Was case referred to medical examiner?	Hospital:	nt 2□FR	/Outpatien	t 3 DOA	th o a	eath (Check only on Home 5 Reside		ther /Snec	64)
ng Phy fter thii		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	y 28	b. Time of Injury			28d. Describe ho			,,,,
ttendi death. ctor: A / the fu	catl	2 Accident investigation 3 Suicide 6 Could not be	1	ry - At home	farm str	M 1	Yes 2 No	28f Location (St	reet and Num	ber or Rur	al Route Number,
ital or A	Certification:	4 Homicide determined	building, etc			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town			
Hospi 24 hou Funer	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	y sician: To the best on the basis of and manner states	examination	dge, death and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	ce, and due to the ca curred at the time, d	ause(s) and mate and place	nanner as s , and due t	stated. to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	Unhal			29c. Licer	ise number	6	9d. Date sign	ed (Morith,	
H-1		30. Name and address of person who of	completed cause of de	ath (Item 23	Ba) (Type,	Print) 1 2	-6 op	al ct	MO) 1	1740
Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature		į	Mager	, , ,			
OHMH 17 Rev 1/2	200	\$ & ₀	Allenger	ar A	f	and .		-			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	Maryland		artment rtificate			ind Me		jiene	16	13218
	A 34	H ₁	1. Decedent's Name (First, Middle, Last)							2.	Date of Dea Month	th Day	Year	3. Time of Death
i de la composition della comp	Physici /Medic	_	Helen Louise Oberl	nolzer							April	15.	2006	12:35 AM
	Examir	780	4a. Facility Name (If not institution, give s	treet and number	er)		4b. City, To	own, or Le	ocation of	f Death	-	4c. Coun	ty of Death	
			67 Wayside Avenue						rstov					on County
	Funeral		5. Social Security Number 6. Sex	M 2 X F	Age (In yrs. I		If Under 1 Months I		Hours	Min.	Date of Birth (Month, Day	, Year)		lace (State or Foreign try)
	Director		182–22–9333 Usual Residence of Decedent			78 Yrs.				Se	ept 30	1927	Penr	nsylvania
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Mary First	tor	Maryland Washing	aton		Hage	rstown					,		1 Yes 2 □ No
	r 28a	Directo	10e. Street and Number				10f. Zip C					10g. Citizen o	f What Coun	itry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23a or 28a-f show thet, fire Massical Exerciper court by notified at		67 Wayside Avenue	2				2	1740			U.S.	Α.	
	deat	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13.	Was Deceder	nt of Hisp	anic Origi	gin? (Specif	y Yes or No- can, etc.)	14. R	ace - Americ	
9	or its		1 Never Married 2 Married	1 ☐ Yes 2 [If Yes, Give			1 ☐ Yes 2	NZ.	Specify:	, , , , , , , , , , , , , , , , , , , ,	, 4.0.,	Spec		ite
Maryland 21215-0036	72 hours	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Date:	s:									
,	"nat	Completed	15. Decedent's Educ (Specify only highest grade			(Give	dent's Usual (kind of work DO NOT use	done dur	on ring most	of working		16b. Kind of	Business/Inc	dustry
7	withir ane. than	E G	Elementary/Secondary (0-12)	College (1-40	or 5+)		itress	1011100)				Resta	aurant	
0 7	be filed within 72 ho ital Hygiene. od other than "natur svent, the Modical	e Cc	17. Father's Name (First, Middle, Last)					1:	8. Mother	r's Name (F	First, Middle,	Maiden Suma		
a	2 should be filed and Mental Hygis is marked other aumatic event, III	To B	Walter Scott Day	7is					F]	loren	re Beli	le Mow	erv Da	vis
2	should ind Men s marke umatic	F	19a. Informant's Name/Relationship (Type			19b. Mailir	ng Address (S	Street and				r, City or Tow		
Š	ges 1 and 2 should to of Health and Men if item 27 is marke or other traumatic		Louise Murnighan	(daught	er)	604	Brant'	lov I	Place	Vir	rinia l	Anach	Virmi	nia 23452
ē,	es 1 a of Heis fitem		20a. Method of Disposition		20b. P	ace of Dispo	sition (Name	of	a decidence	Date	9	20c. Location	n - City or To	wn, State
Ē	Pages nent of int: if it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	te _		en Ceme		y 4	4-18-2	2006	Hagers	stown	Maryland
Baltimore,	permit. Pag Department Important: i sny injury o once.		21. Signature of Funeral Service License	X un	,	13	Name and	Address steri	of Facility	Dougl	las A. Hage	Fiery rstown	Funer Maryl	al Home and 21742
8760,	Cate be executed / Medical Examiner Physician and Physicia	dical Examiner	23a. Part1. Enter the diseast, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence as a c	uence of):	© C3		1				(Approximate Interval Between Onset and Death
	The law requires that the death certific: Ne has been signed by the attending pl page 2 should be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetal	death 3[Ectopic preg Other (spec						Date of delive Month	ory Day Year
Division of Vital Records, P.	uires that signed b	व	Part II. Other significant conditions con	itributing to death	n but not resu	Ilting in the u	nderlying cau	use given	in Part I.		23e. Did to	~		ne cause of death?
<u>o</u>	w requires been si should l	Completed								4	24a. Was	an 24b	. Were auto	psy findings available inpletion of cause of
Ä	he lay	E									autop	med?	prior to cor death? 1 \(\sum \) Yes	
<u>ra</u>	sician: Th certificete rector, pag	Ö	25. Was case referred to medical						of Place	of Death (1 ☐ Yes Check only o	2) No	I LI Yes	2U No
5	s cer direct	To B	examiner?	lospital:	atient 2 🗆	ER/Outpatier	nt 3□ DOA	Other		rsing Home		ence 6 🗆 O	ther (Specifi	<i>(</i>)
0	Attending Physician: It death. sctor: After this certifice by the funeral director.		27. Manner of Death	28a. Date of I		28b. Time o		c. Injury a Work?	ıt			ow injury occi		,
<u>o</u>	ktending F death. ctor: After y the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(month),	July 7 July	injury	м		s 2 🗆 N	No				
<u>8</u>	or Attendation of Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building.	Injury - At ho	me, farm, sti	eet, factory,	office		28f	Location (S City or Tow	treet and Nun	nber or Rura	l Route Number,
Ξ	ospital or A hours after unerei Dirse ly filled in by	Cer												
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	sician: To the be ner: On the basis and manner	s of examinal	wledge, deat tion and/or in	h occurred at vestigation, in	the time, n my opin	, date and nion, death	d place, and th occurred	due to the d at the time, d	ause(s) and r late and place	manner as st e, and due to	ated. the cause(s)
	To the Ho within 24 To the Fu completel	ž	29b. Signatule and title of certifier			M	29c. I	License r	number	,		9d. Date sign	ned (Month,	Day, Year)
			Mary M	01		de	0		Dh 6	64	13	OH	1171	06
	, -		30. Name and address of person who co	mpleted cause o	of death (Item	23а) (Туре,	Print)	^ ^			71		i	MD 21740
21	1-3		thing How	ndan	α, M	7:11	301	OLF	16	CI	1710	igers.	town	MD 21740
	Sta Regist		31. Date filed (Month, Day, Year) APR 17 20	32. Regi	istrar's Signa	y. A	artho				/	7		

		-	For State Registrar	State of Maryland / D	epartment of H Certificate of L			ene 0 0	6 32 9
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Anita W. Parso	ns			4		0410 AM
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death		4c. County of	Death
			Constal Hospice A	+ The Lake	Salisby	LTY		Wico	mico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9	Birthplace (State or Foreign Country)
	Director		212-18-6741	M 2⊠F 83	Yrs. Working Days		Feb. 22,		Maryland
	p _		Usual Residence of Decedent	10- 07- 7					10d. Inside City Limits
	aryla ahov	_	10a. State 10b. County	10c. City, Towr					1 ☐ Yes 2 No
	Be-f	cto	DE Sussex	Seafo					
	or 2	Director	10e. Street and Number		10f. Zip Code		10	ng. Citizen of Wh	at Country?
	23a		6182 Stefland Driv		19973			U.S.A.	
	emet E	Funeral	Tr. Mariar States	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	or t	by Fi	1 Never Married 2 Married	1 ∐ Yes 2 🖾 No If Yes, Give	1 ☐ Yes 2 No	Specify:		Specify:	TT1
Ö	72 hours after death with the Maryland Insturel, or tteme 23a or 28e-f ahow disel Examiner must be notified at		3 Widowed 4 XDivorced	Year or Dates:	Provident 10			101 IC 1 - (D	White
5	l within 72 ho iene. r than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grade		Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	during most of work	ring	16b. Kind of Busi	ness/industry
12	within ene. then "	E D	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	Clerk	,		Dry C1	Leaners
7			17. Father's Name (First, Middle, Last)		OTELK	18. Mother's Nam	e (First, Middle, N		
ano	D D C	Be				Lola M		,	
Maryland 21215-0036	d 2 should be th and Menta 7 is marked traumatic av	욘	Alonzo W. Foxwell 19a. Informant's Name/Relationship (Ty	rne Print) 19h	Mailing Address (Street a			City or Town St	ate Zio Code)
Ma	12 s h ar h ar r ie				82 Stefland				
di.	s 1 end 2 if Health Itam 27 i		Charles Parsons, J	20b. Place of	Disposition (Name of		Seaford,		ty or Town, State
סר	ages or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ P	temoval from State cemeter	y, crematory or other plac	Whiti	14,2005	Hebro	n, Maryland
ţ	rtmer rtant		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		1111 Memory 22. Name and Addres			Hebro	n, Haryland
Baltimore,	permit. Pages 1 Department of H important: if its any injury or ot		21. Signature of Funeral Service Licens	1.	Short Fur	neral Hom	e _{D-1}	D.D.	100/0
	20204			12/	13 E. Gro	ve Stree	t Deli	mar, DE	19940 Approximate
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.	of enter the mode of dyin	, such as cardiac	. A A	, , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
)	Physician		Immediate Cause (Final disease or condition resulting in death)	Metastatil	Recta!	' Can			
	/Medical Examiner		Testing in death)	Due to (or as a consequence	of):				
		ايا	Sequentially list conditions,	Due to (or as a sonsequence to	off.				
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence t	<i>πγ.</i> -				
	and I-tran	хап		Due to (or as a consequence of	of):				
8760,	cate be executed physicien and the burial-transit	ᇤ							1
87	cate chysi the	dlcal		d					
9	eath certific attanding p I for use as	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregnancy				004 0-44	-1 -1-10
Вох	attan sttan for us	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date Month	•
o.	at the de by the a stached t	/sic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)				
٥.	The law requires that the death certifi ste has been signed by the attanding page 2 should be detached for use as		Part It. Other significant conditions con	ntributing to death but not resulting in	the underlying cause give	en in Part I	23e. Did tob	acco use contrib	ute to the cause of death?
S,	signe	۵	and organization of the same o	The standard of the standard o	. The dilidenty rig deaded give	G. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	1 □ Ye	~	☐ Probably 4 ☐ Unknown
Vital Records,	w require been si should t	Completed						2	
ec	elaw hast je 2 s	du					24a. Was ar autops	y pre	ore autopsy findings available or to completion of cause of
Ξ.		Sol					perfern 1 ☐ Yes		ath? Yes 2000
/ita	ysician: T is certificet director, pa	Be	25. Was case referred to medical examiner?				h (Check only on	e)	
of \	S S S	ဥ	1 ☐ Yes 2 No	lospital: 1 k Inpatient 2 ☐ ER/Ou		4 Nursing H	ome 5 Reside		
	ding Ph. h. After thi funeral	ë	27. Magner of Death Natural 5 ☐ Pending		Time of 28c. Injun-		28d. Describe ho	w intury occurred	1
9	Attending ir death. ector: After by the fune	atl	∠2 ☐ Accident investigation		M 1 🗆	Yes 2 □No			
Division	or Attendation of the Court of	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (St. City or Town		or Rural Route Number,
	To the Hospitel or Atl within 24 hours after d To the Funeral Direct completely filled in by								
	Hosp 4 hou Fune ely fill	ca	(Check only	nicinm: To the best of my knowledge ner: On the basis of examination an					
	the hin 2: the the nplet	Medical	one)	and manner stated.					
	5 1 to 2	-	29b. Signatore and title of certifier	1//// 11/	29c. License	1778	- 29	-	(Month, Day, Year)
	123		Pref C	est, WV	1 00	0010		7-17	-06
	00		30. Name and address of person who co	A 1 1 11	(Type, Print)	1777	- hel	1.1	11601
	Sta		30. Name and address of person who co	ompleted cause of death (item 23a) Oast / Hospitu 32. Registrar's Signature	(Type, Print) Po Box	1733 8	Salish	y MD	21802

Hospital or Attending Physician: after death

Division of Vital within .

Carol Allan, MD 31. Date filed (Month, Pay Year) Registrar

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

determined



(Specify) Major Road / Highway

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E

or Town, State) Dover Bridge Road, Preston, MD

April 12, 2006

29d Date signed (Month, Day, Year)

OŘÍGINAL

			1 - For State Registrar	-		nd / Depa	artme		ealth and Death		tal Hyg		06	132	21
	Dhusisi		1. Decedent's Name (First, Middle, I	ast)							Date of Deat	Day	Year	3. Time of	Death
	Physici /Medio		JOSHUA M	ICHAEL PO	WELL					A	pril 1	9, 20	006	2:00	A^{M}
	Examir	er	4a. Facility Name (If not institution, g	rive street and numb	oer)		4b. Ci	ty, Town, or	Location of Dea	th		4c. Cou	unty of Death		
			Memorial Hospit					Cumbe				A1:	legany		
5.0	Funeral			. Sex 7. 1 X M 2 □ F		. last birthday) Yrs,	Month	der 1 Year is Days	If Under 24 Hrs Hours Min	. (Date of Birth Month, Day,			place (State or ntry)	r Foreign
	Director		215 33 1202 Usual Residence of Decedent		14		İ			JŢ	JLY 2	1991	MARY	LAND	
viand	M N		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside Cit	ty Limits
Ma	r 28a-f ehow	tor	MARYLAND ALLEGA	NY	FRO	OSTBURG	!							X □Yes	2 🗌 No
death with the Maryland	or 28	Director	10e. Street and Number			DIDORO		Zip Code			10	g. Citizen	of What Cou	ntry?	
£	23	ai	42 LINDEN STREE	\mathbf{T}				215	32			U	.s.		
		Funerai	11. Marital Status	12. Was Deced Armed Forc	es?	J.S. 13.	Was De	cedent of Hi	spanic Origin? (S n, Mexican, Puer	Specify no Rica	Yes or No- n, etc.)		Race - Americ Black, White,		
.0036 hours after	5 💆	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	K] No	1		2 ₹ No	Specify:				ecify:		
21215-0036	"naturel",			Year or Date	9S:	100 Dece			*				WHI		
15. E	2 3	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give	kind of 1	sual Occupa work done d use retired:	luring most of wo	orking		ob. Kina o	of Business/In	austry	
212 Will	nd Mental Hygiene. marked other then imatic event, the Mi	E	Elementary/Secondary (0-12) unk	College (1-4	or 5+)	DISA						DT	SABLED		
ם פ	ent,	BeC	17. Father's Name (First, Middle, La	st)		T DIDA	יחחחי	1	18. Mother's Na	me (Fir	st, Middle, N				
and property of the property o	ic ed	To B	FREDERICK POWEL	L, JR					KATHL	EEN	(hoye) POW	ELL		
Maryland	and N		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addre	ss (Street a	nd Number or R	ural Ro	ute Number,	City or To	wn, State, Zip	Code)	
	Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "n eny Injury or other traumatic event, the Mical Once.		FREDERICK POWELL	JR FATH	ER	42	LINI	EN ST	REET FRO	OSTE	BURG MI	215	32		
Baltimore,	of He		20a. Method of Disposition	□ Bomoval from St		Place of Dispo	sition (A	lame of r other place	MATORY 4	Date	2		on - City or To		
in Fa	ment ant: I ury o		1 ☐ Burial 2 XX Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)	are T.HF	E CUMBE	RLAN	ID CRE	MATORY 4	4-21	06 (CUMBE	RLAND	MD	
	Departr Import eny inj		21. Signature of Funeral Service Lic	ensee		22	. Name	and Addres	s of Facility		61) w.	MAIN S	TREET	
m 8	2 5 9		Man M.	Sowe 3	Mod	2547 8	OWER	S FUN	ERAL HO	MF.	P A F	ROSTB	URG MD	21532	
	nysician Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a Pres	sed the dea th line.	th. Do not ent	er the m	ode of dying), such as cardia	c or res	piratory arre	st,		Approximate Interval Betw Onset and D	veen
E	xaminer			Save	consecutive D	postoic	Live	1.0	or Die	005	20			100	,ce
	- "	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	quence of):	1774		900	CLE	1			3 gea	12
60, be executed	been signed by the ettending physicien and should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Men	tal E	20 tarr	107	ron-	Porto	un	4		ij.	1 upa	CS
0,0	en ar ırial-t	Ĭ.	resulting in death) Last	Due to (or	as a consec	quence of):		1	(9	
0	S S	ical	•	La Cere	pral	Palso	4- (pour	riplea	ic			11	Tyea	.05
c 68	ing pt	Med	IF FEMALE:				J		1 0	,		7			
I Records, P.O. Box 68 The law requires that the death certifica	Itendi	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 ☐ Live birt	n 2 ∐ Feta	al déath 3 [Ectopic	pregnancy					Date of delive	,	'oor
O. B.	the e	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow		death 5	Other (specify)					MOHE	Day Y	'ear
P.O.	d by	튄	Part II. Other significant conditions	contributing to deal	th but not rec	culting in the u	a dock in		a in Dort I		22a Did tab		antabuta ta ti	ne cause of de	aa4b2
Records,	signe d be o	ğ	Tarris Strong Significant Containing	contributing to deal	11 DUI 1101 143	saking in the th	iden iyang	cause give	II HI Fall J.	- 1				ably 4 🗆 U	
O. C.	peen	Completed			-					-					
3e a	2 5	шb									24a. Was an autopsy perform		b. Were auto prior to con death?	psy findings a mpletion of ca	vailable iuse of
= = = = = = = = = = = = = = = = = = =	icete r, pa										1 ☐ Yes 2	No	1 Yes	2 🗆 No	
of Vital	n. After this certificete ha funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:		1		Othe	26. Place of De						
P S	r this	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of		202	4 Industry		5 Resider Describe hor			v)	
e gig	th. : Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month,	Day Year)	Injury	М	28c. Injury Work 1 🗆 Y	? ′es 2 ⊡No	1200		· injury co.	341100		
Division or Attending	ctor by the	fica	3 Suicide 6 Could not	be 28e. Place of	Injury - At h	ome, farm, str	eet, facti			28f. L	ocation (Str	et and Nu	ımber or Rura	l Route Numb	
Di o	Direction to	ert	4 ☐ Homicide determine	building	, etc. (Specia	<i>fy</i>)					City or Town,	State)			
Division To the Hospital or Attending	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one) 1 Certifying F	Physician: To the base aminer: On the base and manner	is of examina	owledge, death ation and/or inv	occurre estigation	ed at the time on, in my op	e, date and place inion, death occi	e, and curred at	due to the car the time, da	use(s) and le and plac	manner as st	ated. the cause(s)	
To t	To tl	Σ	29b. Signature and title of certifier		0.	11/0	2	9c. License	number		29	d. Date sig	ned (Month.	Day, Year)	
			I'm cher	a Z	wit	asmy		DJF	222			April	120,	2006	
	3		30. Name and address of person wh	o completed cause	of death (Iter	m 23a) (Type,	Print)	_		\	, \		-		
	1		Michael A. Levi	tas m.D.	500) Gree	20.	Stree	t, Cur	nbe	clan	1. m	D 21	502	
1	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signa	ature	Es .								

State of Maryland / Department of Health and Mental Hygiene [] [] For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Ramona G. Roman April 8, 2006 9:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sunrise Nursing Home Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🛣 F 114-05-0120 96 Yrs. Director 1909 Puerto Rico Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 28a-f show other traumatic avent, the Mudical Exeminar must be notified at 1 X Yes 2 □ No Director MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 12625 Safety Turn 20715 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Puerto Rican ģ Specify: White 3 XWidowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "ray fourty or other traumatic avent, the Med ORGS. College (1-4or 5+) Elementary/Secondary (0-12) 12 Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Garcia 2 Sixta Lugo 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Manuel W. Roman/Son 12625 Safety Turn Bowie, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □Donation 5 □Other (Specify) Ft. Lincoln Cemetery 4/12/2006 Brentwood, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MUUTI-OREAN /Medical Due to (or as a consequence of): Examiner RUNA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical *fF FEMALE* 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 13 menths?

1 Yes 2 No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably 1 TYes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 2 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: P 2 NO 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how infury occurred 1 Natural 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a To the Funeral I Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 1741698 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Desons buy tyou Saspan dominan, no 116 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 1 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Co	
State of Maryland / Department of Health and Menta Certificate of Death	I Hygiene

			1- State of Maryland / Department of Health Certificate of Death		tal Hygie	CUUU	13223
	0		Decedent's Name (First, Middle, Last)		ate of Death		3. Time of Death
	Physici		Anna Louise Roller		Apr.	Day Yea	
4	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		140	4c. County of D	
1	LXamii		Fahrney Keedy Nursing Home Boonsbor	50		Washi	ington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	er 24 Hrs. 8. D	ate of Birth Month, Day, Ye		Birthplace (State or Foreign
	Director		220–18–0755 1 M 2 XF 94 Yrs. Months Days Hours	Min. Jar	nuary 2	1912 I	Country) Pennsylvania
	ъ		Usual Residence of Decedent	, gaz	idai y z		CIBBJIVANIA
	how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-f	cto	Maryland Washington Boonsboro				1 ☐ Yes 🏋 ☐ No
	th th	Director	10e. Street and Number 10f. Zip Code		10g.	. Citizen of What	Country?
	ours after death with the Marylan elf, or Items 23a or 28a-f show Exartimer i well by a difficed at	a	8507 Mapleville Road 21713			U.S.A.	
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexico	Origin? (Specify)	Yes or No-	14. Race - A Black, W	merican Indian,
9	or It	F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes Give 1 ☐ Yes 2 ☒ No Specifi		,	Specify:	
8	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show deat Examinate untitle Indillied at	d by	3 \(\overline{\text{Widowed}} \) Widowed 4 \(\overline{\text{Divorced}} \) Divorced Year or Dates:			орвену.	White
5	be filed within 72 hours aft ital Hygiene. Ind other then "naturel", or event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during mo	ost of working	168	b. Kind of Busine	ss/Industry
121	within ene. then "	mp	Elementary/Secondary (0-12) College (1-4or 5+)			T	
72	filed Hygie other		12 Administrative As 17. Father's Name (First, Middle, Last) 18. Mot	ther's Name (Firs			ice Company
auc	ntal led o	Be					
Ë	d 2 should be th and Mental 7 Is marked of treumetic ever	ဥ	Simon Mervin Brenize 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nurn.	Sara Na			7in Code)
Maryland 21215-0036	7 - 7 -						
	is 1 and 2 of Health item 27 l		Anita L. Long (daughter) 11319 Manse Rd. I	Hagersto Date		VIANG 21 c. Location - City	
Baltimore,	of of		1X Burial 2 ☐ Cremation 3 ☐ Removal from State	4 10 2			
ij	permit. Pag Department Important: I eny injury o		. 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery ! 21. Signature of Funeral Service Licensee -2 22. Name and Address of Fac		_		wn Maryland
Ba	permit. Pag Department Important: I eny injury o			_		_	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a				ryland 21742 Approximate
			shock, or heart failure. List only one cause on each line.	as cardiac or res	piratory arrest,	•	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				
	Examiner		Due to (or as a consequence of):				
		100	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of);				
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events				
	al-tra	xar	that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit						
687	icate phys	edlcal	d				
×	eath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of	delivery
Вох	atter for L	ciar	in the past 12 months?			Month	Day Year
o.	at the de by the a tached	Physician/Me	1 Yes 2 No 9 Unknown				
Ω.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I.	23e. Did tobac	co use contribute	to the cause of death?
Records,	uires sigr	d by			1 🗆 Yes	2 □No 3 □	Probably 4 Donknown
00	w require been si should l	Completed			24a. Was an	24h Were	autopsy findings available
Re	The lav	m			autopsy performed	prior t death	to completion of cause of
a		CO	25. Was case referred to medical 26. Place		Yes 2	Mo 1□Y	es 2 No
Vital	Physicien: This certificate al director, p	o Be	examiner? Hospital:	oce of Death (Chi		- C TO:	
of		\vdash	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at	40.00		e 6 □Other (S injury occurred	респу)
on	ding I h. After funer	tlor	Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐			. ,	
Division	Attendi death. ctor: A y the fu	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office				Rural Route Number,
Θį	after Dire	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, S	itate)	
	spite		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and d	ue to the caus	e(s) and manner	as stated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	eath occurred at	the time, date	and place, and d	lue to the cause(s)
	To th within Fo th compl	Me	29b. Signature and title of certifier 29c. License number	_ ^	29d.	Date signed (Mo	onth, Day, Year)
	, , , , , ,		found mental DOGO	396	04	(171	0 (
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	oral	4	1	
3	H-4		FARID MURSHED, MD	4 6484	0 V V	MD	21740
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	<u> </u>	ſ	
20.5	Regist		AFR 2 (2000) Beern M. Boarded	-			

06-2AKG

Loretta M. Randolph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

.24	47		. For	State of	Maryland	d / Depa	artmen	t of H	ealth a	and M	fental Hy	aiene 🗅	0.0	10001
			1 - State Registrar				rtificate					Reg. No.	Uto	13224
٦	Physici	an	Decedent's Name (First, Middle, La	•							2. Date of Dea	Day	Year	3. Time of Death
	/Medi	cal	Loretta Mae Rando								April		06 ^{Year}	10:34 A M
	Examir	ner	4a. Facility Name (If not institution, given 38230 William Cou	urt			Char	:lott	Location o	11			nty of Death St. Ma	
	Funeral Director			Sex 7 1 ☐ M 2 【X F	7. Age (In yrs. la 86	ast birthday) Yrs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da	th y, Year)		nplace (State or Foreign untry)
			Usual Residence of Decedent		00		L				Dec.15	,1919	Tenr	nessee
	anylan show		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Ba-f	Directo	Maryland St. Mar	Y	Chai	rlotte								1 ☐ Yes 2X No
	with t	D.	10e. Street and Number				10f. Zip					10g. Citizen o		untry?
	me 23	Funeral	38230 William Co	12. Was Deced	lent Ever in U.S	3. 13. \		622 ent of His	spanic Orio	ain? (Spe	ecify Yes or No-	U.S.7	A. lace - Amer	ican Indian
ဖွ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23a or 28a-f show aumstic event, the Medical Examiner must be notified at	F	1 Never Married 2 Married	Armed Ford	217 No					, Puerto	ecify Yes or No- Rican, etc.)	8	lack, White	, etc.
ဗ္ဗ	ural',	d by	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dat	les:		1□Yes 2	X) NO	Specify:			Spec	^{cify:} Whi	ite
5	"nati	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	dent's Usua kind of wor DO NOT us	k done d	urina most	of work	ing	16b. Kind of	Business/Ir	ndustry
7	withii iene. then	d Ho	Elementary/Secondary (0-12)	College (1-	4or 5+)		maker	,				Her H	Home	
ğ	e filed I Hyg other	BeC	17. Father's Name (First, Middle, Last	")		1101110			18. Mothe	r's Name	(First, Middle,		-	
<u> a</u>	should be ind Mental i marked of umatic ev	ToB			Simmons	3			Ţ	Jnkno	own			
Maryland 21215-0036			19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	r, City or Tow	m, State, Zi	²⁰⁸⁷ 2087
a)	1 and 1ealth 1m 27 ther tr	άy	Joe F. Randolph 20a. Method of Disposition	sc	on	10a	Chric	tash	Or Ar	70	IInit 21	2, Gait	thersk	ourg, Md.
Jor	0 0		1 DABurial 2 ☐ Cremation 3 ☐		tate 200. Fig	metery, cren	natory or oti	her place	Apri	.1 12	2,2006	20c. Location	n - City or T	own, State
Baltimore,	permit. Pag Depertment Important: I eny Injury c		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Services in the serv		Mary	yrand	. Name and	aus	Cenje	er y		Chelte	enham,	Maryland
ä	Dep eny		mille	<u> </u>	MO(W	illia	ms F	unera	ıl Ha	ome, P.A	Α.	147	20540
			23a. Part1. Enter the 3 ise ise, or comshock, or heef fail ve. List only	plications that car	used the death.		2/0 H er the mode	awth of dying	orne , such as o	RO. cardiac d	Indiar	n Head, rest.	Md.	Approximate
	Pnysician	ai i	tmmediate Cause Fin disease or condition	24	The	11.	_ (2	o.t.	H	referesin	Cal		Interval Between Inset and Death
	/Medical Examiner		resulting in death)	a Due to (o	r as a con equ	ence of:	7 0		Cury	1	- face	L CNU	in the second	Ur Distin
E	LAGITITIES	٠,	Sequentially list conditions,	b. —										
	pet Ilsu	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conseque	ence of):								
	be executed sicien and burial-translt	Examiner	that initiated events resulting in death) Last	c. Due to (or	r as a conseque	ence of):								
8760	ate be hysicie the bur	dicai	(d										
0	ng ph	Medi	IF FEMALE:											
Box	The law requires that the death certificate be executed to has been signed by the ettending physicien and sage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Fetal o	death 3 🗆	Ectopic pre	gnancy					ate of deliv	•
-	at the de by the e	ystc	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of dea vn	ath 5⊡	Other (spe	ecify)					Month	Day Year
0	that the		Part II. Other significant conditions of	contributing to dea	th but not resul	ting in the un	iderlying ca	use giver	n in Part I.		23e. Did to	bacco use co	ntribute to t	he cause of death?
Vital Records,	quires n sign	ed by	1					_				es 2 🗆 No		L/
ပ္ပ	aw require is been si 2 should t	Completed									24a. Was a		. Were auto	opsy findings available
ř	The law ate has page 2.	mo									autops perfor	sy med?	prior to co death? 1 X Yes	mpletion of cause of
<u> </u>	vicion: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or		1,20,163	2 140
5	Attending Physicien: r death. ector: After this certifica by the funeral director.	ပ	1X Yes 2 No	Hospital: 1 Inp		R/Outpatient			4 🗀 Nur					wat scene
	ing Ingli	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	2 12	Day Year)	28b. Time of Injury	9 M	Work?	at es 2.MoN		28d. Describe hi	ow injury occu	urred	
DIVISION	Attendi death. octor: A sy the fu	fica	3 ☐ Suicide 6 ☐ Could not b	e John Bloom	f Injury - At hon	ond to	Lours		2 1		28f. Location (Si	treet and Nun	ther or Rura	al Route Number,
S	al or	Sert	4 Homicide	building	, etc. (Specify)	phi	dunce				City or Town	n, State) 34	230 h	Pallian Court
	ospit hours unera ly fille	cal	29a. Certifier (Check only (Check only (Check only) (Check only)	ysician: To the b	est of my know	ledge, death	occurred a	t the time	, date and	place, a	and due to the c	auco(c) and a	nanner as s	tated
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	fedicai	one)	and manne	r stated.	on and/or inv				occurre	ed at the time, d	late and place	, and due to	o the cause(s)
	or with or co	Σ	29b. Signature and title of certifier	11 11	-/		29c.	License			2	9d. Date sign	ed (Month,	Day, Year)
•			1 herden 1	1. 147	gray			0.	C.M.1	Ε.		April	2, 20	006
	HB4		30. Name and address of person who THE WOLK M. K	3-6		111	Penn	Stro	or 1	Ralt-	imore, 1	Marri c	nd 21	1.2∩1
2	Sta	te	31. Date filed (Month, Day, Year)	32/Reg	gistrar's Signatu	ILB TTT	T (21111	DULE	ا وات	vart.	THOLE,	патута	iiu Z	1201
	Registr	ar	APR 1 6 20	Jud Jude	الكر متانا	Jul.	1							
						1								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRTL 2006 RUTH NELLWYN RIEVES 16^y 12:10PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WILLIAM HILL MANOR EASTON TALBOT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
MAR 19, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1□M 20 F 460-22-0923 TEXAS Yrs. 82 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f show If item 27 is marked other than "neturel", or iteme 23a or 28e-1 shov or other treumatic event, the Madical Exacilities (suited) Yes 2 □ No Director TALBOT EASTON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMAN'S LANE 21601 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Itam any injury or other trainment. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐Xio WHITE Specify: Specify. 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) METHODS ENGINEER ELECTRONICS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VIRDIE CRAGETT AZA NELSON ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIBBY DALTON/DAUGHTER 9671 GULLEY'S COVE LANE, EASTON, MD 21601 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State RESTLAND MEM. PARK 4/21/2006 * 4 □ Donation 5 □ Other (Specify) DALLAS, TEXAS 21. Signature of Funeral Service Licensee Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injur that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) detached 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **X0**No or Attending Physician: director. 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of ce D35284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8. Washington St Easton mo 2/601 10 219 AND NEA

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 1 7 2006

32. Registrar's Signature

			For State Registrar	State	of Maryla	-	artment of H <i>rtificate of l</i>			giene Reg. Nö.	006	13226
	399	¥	1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea			3. Time of Death
	Physici		Bachuba T. R.	ana					Month	Day 16	Year 2006	1:50AM
	/Medic Examin		4a. Facility Name (If not institution		number)		4b. City, Town, or	Location of De			County of Death	
* :	Exami		University of Ma	5.10-4 M-	dia-1 Ca	ater	Baltim	010				
÷.	Funeral	-	5. Social Security Number	6. Sex	7. Age (In yi	rs. last birthday)	If Under 1 Year	If Under 24 H	s. 8. Date of Birt	h	9. Birthp	place (State or Foreign
	Director		221-64-3438	1 ☐ M 2 🔀 F		Yrs.	Months Days	Hours Mi	10/3/1	947	Cour	ntry)
			Usual Residence of Decedent								Keny	ya
	ylan		10a. State 10b. County		10c.	City, Town or Lo	ocation				1	0d. Inside City Limits
	Mar Mar	to	Maryland Wice	omico		Delmar						1X Yes 2 ☐ No
	r 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	3a o	0	9461 Ocean H	ighway			2187	5		USA	P.	
	filed within 72 hours after death with the Maryland Hyglene. ther then "naturel", or fleme 23a or 28a-f show ther, the Madical Examinar must be notified at	Funeral	11. Marital Status		ecedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin?	(Specify Yes or No-	1	4. Race - Americ	
0	or its		1 ☐ Never Married 2 Marr	ned 1 ☐ Yes	Forces? s 2 X No	1			eno Hican, etc.)	-	Black, White,	
3	urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, (Year or			1 ☐ Yes 2 No	Specify:		3	Specify: Inc	lian
Š	2 ho	Completed by		t's Education	۷۱	16a. Dece	dent's Usual Occupa	ation		16b. Kin	d of Business/Inc	dustry
21215-0036	hin 7	ple	(Specify only higher Elementary/Secondary (0-12)	- T	(1-4or 5+)	life.	kind of work done of DO NOT use retired	turing most or w	onking			
7	d with	ПО	10	_	(1.10.01)	Hom	emaker			D	omestic	
ַ	othe	Bec	17. Father's Name (First, Middle,	*				18. Mother's N	ame (First, Middle,	Maiden S	Surname)	
Maryland	2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. Is marked other then "naturel", or items 23a or 28a-f show aumatic event, the Madical Examinar must be notified at	ToE	Mukundsinh Jac	deja				Lilak	oa Zala			
ary	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relations				ng Address (Street					Code)
	and 2 Balth a n 27 is		Takhatsinh Rana	a/husbanc	ď	946	51 Ocean B	lighway.	Delmar,	MD 2	51875	
ē.	s 1 a f He ifem othe		20a. Method of Disposition			. Place of Dispo	osition (Name of matory or other place	ا (م	Date	20c. Loc	ation - City or To	own, State
Ë	Pages nent of int: if it		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S				/ Cremato		11/06	Sali	sbury,	MD
Baltimore,	permit. Pages Department of Important: if if eny injury or c	1	21. Sa fat re of Funeral Service				2. Name and Addres	s of Facility			-	
ñ	Depression of the part of the		Val nu K	lolls.			Holloway	Funera.	l Home Pro B., Salis	ofess	sional A	ssociation
			3a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t cause the de	eath. Do not en					MD ZIO	Approximate Interval Between
8.	1		shock, or heart failure. List Immediate Cause (Final	only one cause or	n each life.	<u> </u>						Interval Between Onset and Death
46. ·	Physician /Medical		disease or condition resulting in death)	a	Ereora		ema					
	Examiner		1	Due (to (or as a cons	equence of):						
- 27		-	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a cons	equence of):						
	led isit	- L	Cause (Disease or injury that initiated events	<	(01 00 0 00110	adanios oi).						
_	and I-trar	Examiner	that initiated events resulting in death) Last	c.	o (or as a cons	equence of):					_	
8760	cate be executed physicien and the burial-transit	田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田				,						
8/		dlcal		d				,				
×	death certifi e attending I id for use as	lan/Me	IF FEMALE:	23c If yes	outcome of pred	nancy						
ROX	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	e birth 2 Fe	etal death 3[Ectopic pregnancy			23	3d. Date of delive Month	Day Year
o.	0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Uni		ordeath 5L	Other (specify)					
۵.	taw requires that the as been signed by the 2 should be detache	Physici	Part II. Other significant condition	ons contributing to	death but not r	resulting in the u	inderlying cause give	en in Part I	23e. Did to	bacco us	e contribute to th	ne cause of death?
Records,	ires tha signed I be de	þ		,		g ar the c	moonlying occoor give	J. C. C. C. C. C. C. C. C. C. C. C. C. C.		es 2 🖳		ably 4 Unknown
5	w require been si should I	Completed								0		
ပ္	e taw has b	ğ							24a. Was autop	sy	prior to cor	psy findings available ripletion of cause of
	Thate page	Ö							perfor 1 ☑ Yes	med? 2 \(\text{No} \)	death? 1 ☐ Yes	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?				2,000,000	26. Place of D	eath Check only of	nel		
o V	G is	2	1 ☐ Yes 2 ☑ № 6	Hospital: 1 [Umpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	ar: 4 🗌 Nursing	Home 5 Resid	ence 6	☐Other (Specif)	()
0	Jing Ph After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pendir	/4.4.	te of Injury onth, Day Year)	28b. Time o Injury	f 28c. Injury Work	at c?	28d. Describe h	ow injury	occurred	
0	tendi leath. tor: A the fu	atle	2 ☐ Accident investi	gation				Yes 2 □ No				
Division	i or Atten after deati Director: in by the	Ħ	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 289. Pla	ce of Injury - Al		reet, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Number,
	taio rs aft ai Di ed in	Certification;										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After ormpletely filled in by the funer		29a. Certifier 1 Certifyir	g Physician: To t	he best of my k	knowledge, deat	h occurred at the time vestigation, in my of	ne, date and pla	ce, and due to the c	ause(s) a	ind manner as st	ated.
	the H in 24 the F plete	Medical	one)	and ma	anner stated.				ourred at the time, (acto and p	71a08, a110 008 (0	me cause(s)
	To To To E	Σ	29b. Signature and title of certifie	r			29c. License	number	1	29d. Date	signed (Month,	Day, Year)
	108	-	('0, _, 00)	anades	CIM 2		166	46		Apri	10.	2006
	28		30. Name and address of person	who completed ca	use of death (I	tem 23a) (Type,		_			, ,	
	v.) -		Chreness Deliver	2711 94	225	Green	65% P.	Mirror	MD	251	361	
1	Sta	ite	31. Date filed (Month, Day, Year)	1	. Pagistrar's Sig	gnature						
82	Regist	ar	APR 1	2 2006	Malera	H. D	boste					

cudder, Sedrick	1- For State	te of Maryland	ype or Prir I / Departme <i>Certifica</i>	ent of H	ealth and		, 0	. 21	06 1322
Physician/	Registrar 1. Decedent's Name (First, Middle, I	_ast)			o da in		2. Date of Dea	icg. Ito.	3 Time of Death
Medical Examiner	SEDRICK		SCUDDER				April 8, 20	Day Yea	4:06
	4a. Facility Name (if not institution, Prince George Hospital		r)		city, Town, or heverly	Location of Death	1	4c. County Prince (of Death George's
Funeral	Social Security Number 6.	Sex 7. A	ge (In yrs. last birth		Under 1 Year			rth (MM/DD/YYY)	Y) 9. Birthplace (State or Foreig
Director	215-19-4686 Usual Residence of Decedent	X M 2 F	25	Yrs.	Months Days	s Hours Mir		20 1980	WASHINGTON, DO
nd how any ce.	10a. State 10b. County	CEODCE!C	10c. City, Town o		P				10d. Inside City Limits
th the Maryland 23a or 28a-f show notified at once.	MD PRINCE 10e. Street and Number	GEORGE'S	MITCHE		f. Zip Code		1	0g. Citizen of Wi	21
er death wi , or items r must be Funera	11600 TRILLUM ST 11. Marital Status 1 X Never Married 2 Marr 3 Widowed 4 Divor	12. Was Deceder		13. Was De If Yes, s	20721 scedent of Hispopecify Cuban,	panic Origin? (S _l , Mexican, Puerto	pecify Yes or No Rican, etc.)	White	e - American Indian, Black, e, etc. BLACK
urs aft tural" mine	15. Decedent's Education (Specify	or Dates:	ompleted) 16a. D	_		ion (Give kind of v	vork done	Specify:	usiness/Industry
72 hou 1 "nai al Exs	Elementary/Secondary (0-12)	College (1-4 o	during			OT use retired)	ron done	TOD. INITIA OF BE	ionieso/middstry
5-0036 ed within 72 hour tygiene other than "natu the Medical Exar Completed		2 yr		CLERK		- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		GOVERN	MENT
215-0036 be filed within 7 atal Hygiene rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, La				1	18.Mother's Name	e (First, Middle, I	Maiden Surname)
AD 21215-0036 2 should be filed within 72 h and Mental Hygiene 27 is marked other than "n matic event, the Medical E To Be Complete	SAMUEL SCUDDER 19a. Informant's Name/Relationship	-	19b.	Mailing Add	dress (Street	WILLIE t and Number or I	HYMAN Rural Route Nur	mber, City or Tow	n, State, Zip Code)
ore, MD ss t and 2 sho of Health and If item 27 is her traumati	SAMUEL SCUDDER 20a. Method of Disposition 1 X Burial 2 Cremation	_	20b. Place of	600 TI Disposition ry or other p	(Name of cerr	STREET]	MITCHEL:	LVILLE , M 20c. Location -	IARYLAND 20721 City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If ite	4 Donation 5 Other Spec 21. Signature of Funeral Service Lig	cify:	MT. OI	IVET			5/2006 B. JE		NGTON,DC NERAL HOME
m ឱ្យី អ៊ូ <u>ទី</u> Physician	23a. Part I. Enter the disease, or co	mplications that cause	d the death. Do not	7474 enter the m	LANDOV	ER ROAD	LANDOV	ER, MARY	LAND 20785 Approximate Interval
/Medical Examiner	failure. List onl one cause on Immediate Cause (Final disease or condition resulting in death)	each line. a. Multiple Injurie Due to (or as a con	s						Between Onset and Death
	Sequentially list conditions,	b.							
nine.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con c.	sequence of):						
ecuted and transit al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
), oe execurician and inial - tra dical	UNPENDED	AMENDED							
68760 ertificate I ding phys e as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	ome of pregnancy 2 at time of death 5	Fetal d	eath 3 [Ectopic pregna	ancy	23d Date of Month	delivery Day Y ear
D. Box the death of by the atten ached for us	1 Yes 2 No 9 Unkno	9 Unknown							
i, P.O. ires that the signed by be detach	Part II. Other significant condition	s contributing to dea	ith but not resulting	in the under	lying cause gi	iven in Part I.	23e. Did to		bute to the cause of death? Probably 4 Unknown
of Vital Records, ng Physician: The law requires ther this certificate has been sig- meral director, page 2 should be 7: To Be Completed							24a Was autop	sy p	Vere autopsy findings available prior to completion of cause of leath?
							1 Yes		Yes 2 No
Vital ysician: his certif director,	25. Was case referred to medical examiner?	Hospital: 1 Innat	ient 2 🗸 ER/Out	tpatient 3		of Death (Check Other'd Nursin	-	Residence 6	Other
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director, edical Certification: To Be C	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of In	urv 28b Ti	me of Injury	28c. Injury	y at Work?	28d. Describe I	now injury occurre auto collision	
Division or spital or Attending hours after death neral Director: After filled in by the function:	2 Accident Investig 3 Suicide 6 Could n	ation, ot be 28e. Place of I	njury - At home, far				28f. Location (8		er or Rural Route Number, City
Divi		sician: To the best of r		h occurred a		te and place, and	WB Rt. 50 (due to the caus	Cheverly MD, e(s) and manner	as started.
To the Hos within 24 h To the Fun completely	one) 2 Medical Examin	ner:On the basis of ex- and manner stated	amination and/or in	vestigation,	n my opinion,	death occurred a	t the time, date	and place, and d	ue to the cause(s)
- (a) ×	29b. Signature and title of certifier	10.0			29c License			29d. Date signe	ed (Month, Day. Year)
9	30. Name and address of person wh	HELLA	death (Item 23a)		O.C.N	Л. E.		April 8, 200	06
De		stant Medical Exa		enn Stre	et, B a ltimo	ore, MD 2120	1		
State Registrar	31. Date filed (Month, Day, Year) APR 1 2 2006	32. Regist	ar's Signature	•					

DHMH 17 Rev 1/2001 OCME 10/2003

		•	State of Maryland / Department of Health and 1- State Registrar Certificate of Death	Mental Hygie	ZUUb .	13228
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Rochelle Shusterman	1	Day Year 2006	2:30 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ith	4c. County of Death	
			11922 Bargate Ct Rockville		Montgome	ry
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr.	. (Month, Day, Ye	ear) Cou	
	Director	}	104-32-5432 64 11s. Usual Residence of Decedent	Jul 7,	1941 New	York
	yianc		10a. State 10b. County 10c. City, Town or Location			0d. Inside City Limits
	Ba-f	cto	Maryland Montgomery Rockville			1 ☐ Yes 2 🕅 No
	or 28	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	ntry?
	ath w		11922 Bargate Ct 20852		USA	
	er de item	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Never Married 1 □ Ves 2 □ No	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Btack, White,	
36	irs aft	by F	1 □ Never Married 2 ☐ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify:	1+0
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow ha Madical Examinar must be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	166	. Kind of Business/In	<u>ite</u>
215	thin 7	Completed	(Specify only highest grade completed) [Sive kind of work done during most of work done during	orking		
2	ed wi	Con	5+ Director of Activiti		Senior Cit	izens
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle, Mai	den Sumame)	
<u>₹</u>	Mendarka Jarka	ဥ	Harry Kaufman Molly			
Mai	12 st h and 7 ie n traun	8	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			Code)
e,	Healt Fm 2		Norman Shusterman/Husband 11922 Bargate Ct, Ri	ockville, N	ID 20852 Location - City or To	own. Slate
no.	S T E S		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)			
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show emportant: If item 27 is marked other than 100 in the Medical Examination and 100 in 1		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHi			
Ba	Ded Grim Page		Olad Donnell 11800 New Hampshi			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	MA		Onset and Death
4	/Medical		resulting in death) Due to (or as a consequence of):	, ,		
	Examiner		Sequentially list conditions, b.			
	₩ # # # # # # # # # # # # # # # # # # #	Examiner	If any, leading to immediate Due to (or as a consequence of), cause. Enter Underlying Cause (Disease or injury			
_	and and II-tran	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):		_	
8760,	cate be executed physicien and the burial-transit	dical E				
687		edic	0.			
Box	eath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of delive	ery
	thet the death ed by the atte detached for	sicia	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
P.O.	thet the ed by th detache	h.	9 LI UNKNOWN			
	S C e	٥	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to t	
ord	w requires been sign should be	Completed		1 Tes	2KINO 3 Prot	ably 4 Unknown
ec	as b	npie		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
ᆵ	The ete			performed		2 No
Division of Vital Records,	Physician: The I	Be	examiner? Hospital:	eath (Check only one)		
o	Phys rald	To	, Emparient 2 Envolupation 3 DOA 4 Intuising	Home 5 X Residence		y)
on	th th : After tuner	tion	27. Manner of Death 1 Naturat 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No		,,	
5	l or Attending after death Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office		t and Number or Rura	A Route Number,
ā	s after si Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, S	rate)	
	To the Hospitel or Atlending Ph within 24 hours after death To the Funerel Director: After th completely filled in by the funeral	edicai (29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)	e, and due to the cause	e(s) and manner as s	tated.
	within 24	ledi	one) and manner stated.			
	5 t i v i	Σ	29b. Signature and title of certifier 29c. License number		Date signed (Month,	uay, rear)
	12		mb 33388	7	סיןיוןד	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reatherine Asatiani washingto	erooir k	20007	
	Sta		31. Date filed (Month, Day, Year) - 32. Egistrar's Signature	, , ,	J	
	Registr	ar	APR 1 2 2006 Seem 1 19			

		1 - For State Registrar	State of Marylan			of Health of Deat			iene () (16	13229
Physici /Medio		1. Decedent's Name (First, Middle, Last, Vesta Iola	Secrest					2. Date of Deat Month April	14,	Year 2006	3. Time of Death 4:50p M
Examir	er	4a. Facility Name (If not institution, give Williamsport I 5. Social Security Number 6. Se	Nursing Home		Wil If Under 1			8. Date of Birth	Wash	ningt	
Funeral Director]M 2\\ F 93	Yrs.		Days Hours	s Min.	8. Date of Birth (Month, Day, Oct 4	1912	More	lace (State or Foreign try) Jan counts WV Od. Inside City Limits
th the Maryla or 28a-f ahor	Director	MD Washine	gton Wi	illiar	nspor	ode		1	0g. Citizen of		Y☐Yes 2☐No
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show say injury or other traumatic avant, the Madical Examinar must be mailined at once.	by Funeral D	154 N. Artiza: 11. Marital Status 1 Never Married 2 Marned 3X Widowed 4 Divorced	n St. 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:					ecify Yes or No- Rican, etc.)	Bla	· A ce - Americ ck, White, o fy: Whi	etc.
od within 72 hor giene. or than "nature", the weeken is	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 8th grade	cation e <i>completed)</i> Cottege (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use SES a	done during m retired) id		ring	16b. Kind of B	ital	dustry
y later ould be file I Mental Hy narked oth	To Be (17. Father's Name (First, Middle, Last) Norman P. Whi:		1		F	Berth		ith		
Jes 1 and 2 shot Meelth and 1 it itam 27 lam		19a. Informant's Name/Relationship (7) Shielda M. Sha 20a. Method of Disposition 1 □ 80urial 2 □ Cremation 3 □ F	ank daught		1154	Big Po	ool R Apri	.1 19 /	Pool,	MD - City or To	21711
permit. Peg Department Important: any injury o		4 Donation 5 Other (Society) 21. Signature of Funeral S → 2 Licens	7	22 I	Name and	Address of Fa	200 n Th	6	Funer	ral H	lome, Inc
Physician /Medical Examiner physician up physician and Examiner the pringition and the principle of the prin	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	at the indus	or dynig, such	as cal diac	о гозріваюту вті	33 1,		Approximate Interval Between Onset and Death Cuecks YEALS
w requires that the death certificate been signed by the ettending planduld be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3	Ectopic preg				1	ate of delive	ry Day Year
law requires that less been signed by 2 should be detailed.	Completed by Pt	Parl II. Other significant conditions co	ntributing to death but not resi			use given in Pa	nt I.	1 □ Ye 24a. Was a autops	n 24b.	3 Prob	ably 4 Unknown
VICAL IN iclan: The certificate h rector, pege	Be	25. Was case referred to medicat examiner?	Hospital:			Other	/	th Check only on	2 PNo		2□ No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Certification: To	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At houilding, etc. (Specific	28b. Time o Injury	M 280	c. Injury at Work?		28d. Describe ho 28f. Location (St City or Town	ow injury occu	rred	·
ha Hospita in 24 hours ha Funeral pletely filled	edicai	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Example 2 Medical Example 1	sician: To the best of my kno iner: On the basis of examina and manner stated.	tion and/or in	vestigation, i	n my opinion, o	death occur	red at the time, d	ate and place,	, and due to	the cause(s)
To I Com	M	29b. Signature and title of certifier Cyrtha Ku 30. Name and address of person who c	ompleted cause of death (Item	nds m	29c.	License number	51	ma 150	9d. Date signed Pr. 7	14 d	Day, Year) 2006 12 RN Street 1795
Sta		- 11	Sands MD 32. Rigistrar's Signa	Ili ams	port	WIT	am El	port, M	aryla	nd 2	1795

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2006 Robert Blair Stewart April 10 4:00 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 197 Frenchtown Road Elkton Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 189-24-0614 74 July 8. Director Chicago, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Director MD Cecil Elkton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 197 Frenchtown Road 21921 USA death v by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumer. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korean War White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Aircraft Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Stewart Margaret Jamieson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis A. Stewart/wife 197 Frenchtown Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 04-12-2006 1 Burial 2 Cremation 3 Removal from State R.T. Foard Funeral Home, P.A. ¹ 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun. Maruland 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen Street, Elkton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician MYOCHRDIAL INFMCTION HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ALTERY DISEASE YEARS CORUN ANY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed TEARS PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, DISEASE YEARS OBSTRUCTIVE PULLWART IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed 2 No 1□ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner I Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation s after decrea Afr 1 Yes 2 No 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) determined 4 | Homicide on 24 hours.
The Funeral Directory filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical npletely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOOYTTLI M.A. April 11,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+IVA 304-306 North Street Suite #3 ELHTON DAVID GAR-EL MARY LAND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 2 2006 Registrar

Shue, Cynthia			e Type or P				/aines		
	1- For State Registrar	State of Maryla		ficate of De		мена п	Re	g. No 2006	
** Physician							2. Date of Death Month April 9, 200	Day Year	3. Time of Death
C	4a. Facility Name (if not ins Route 273 @ Blue	titution, give street and nu	umber)		ity, Town, or Lo lkton	ocation of Death	April 0, 200	4c. County of Death	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last				8. Date of Birth		thplace (State or Foreign
Director	183-52-4855 Usual Residence of Decede	1 M 2 F		45 Yrs. N	lonths Days	Hours Min.	Septem	ber 4,1960	untry) $\mathcal{D}\mathcal{E}$
v any	10a. State 10b. Co	unty	10c. City, To	wn or Location					10d. Inside City Limits
laryland 8a-f shov at once.	MD C 10e. Street and Number	ecil	Elk:		. Zip Code		10	g. Citizen of What Cou	1 Yes 2 X No
215-0036 be filed within 72 hours after death with ntal Hygiene. eked other than "natural", or items 23- ent, the Medical Examiner must be no	11. Marital Status 1 Never Married 2	12. Was Der Armed F 1 Yes Divorced of Yes, Give Ye or Dates: (Specify only highest grant) 12. Was Der Armed F 1 Yes Or Dates: (Specify only highest grant) 13. Was Der Armed F 1 Yes Or Dates: (Specify Yes Or Dates: (Specify Yes Or Dates: (Specify Yes Or Dates: (Specify Yes Or Dates: (Specify Yes Or Dates: (Specify Yes Or Dates: (Specify Yes) Or Dates: (Armed F 1 Yes Or Dates: (Specify Yes) Or Dates: (Specify Yes	2 X No ar de completed) 16 du 1-4 or 5+) A 2 A 2 Cob. Place rom State 20b. Place cref	If Yes, s 1 Yes Sa. Decedent's Uring most of worki dministr 19b. Mailing Add 4060 BL ce of Disposition matory or other p 2 bank Ce 22. Name	pecify Cuban, No sual Occupation on glife. DO NOT ative A large series (Street a large) metery and Address of and Address of a large series of the suar Address of a large series of the suar Address of a large series of the suar Address of a large series of the suar Address of a large series of the suar Address of the suar Ad	Mexican, Puerto specify: In (Give kind of w. T use retired) SSISTAM Mother's Name Helen L and Number or F Road, tery, 04- f Facility R.T	t (First, Middle, M easure tural Route Num Elkton, Date 14-2006 Foard	White, etc. Specify: Wh. 16b. Kind of Business/ Technologiaiden Surname) ber, City or Town, State MD 21921 20c. Location - City or Rising State & Jones Fu	Industry $g \hat{oldsymbol{y}}$ e, Zip Code) Town, State
Physician /Medical Examiner	23a Part I. Enter the disear failure. List only one of Immediate Cause (Final dior condition resulting in de Sequentially list conditions if any, leading to immediate cause Enter Underlying (Disease or injury that initial events resulting in death)	ause on each line. sease ath bue to (or as an ause atted Last bue to (or as an ause atted Last a. Multiple Inj bue to (or as an ause atted bue to (or as an ause atted bue to (or as an ause atted bue to (or as an ause atted bue to (or as an ause atted bue to (or as an ause atted bue to (or as an ause atted bue to (or as an ause atted bue to (or as an ause attent bue to (or as an ause atte					, Newarl respiratory arre		Approximate Interval Between Onset and Death
		d. AMENDED							
D. Box 68760, the death certificate be by the attending physici the cheful of the attending physici content for the butter of th	UNPENDED IF FEMALE: 23b. Was decedent pregnar past 12 months? 1 Yes 2 No 9 Part II. Other significant c	t in the 1 Live 4 Pregion 1 Unknown 9 Unknown	nant at time of death	2 Fetal do	(Specify)	Ectopic pregna		23d. Date of deliver Month I	Day Year
Records, P.O. The law requires that the law requires that the law seen signed by tage 2 should be detacted.	Completed by						1 Yes 24a. Was a autops perforr 1 Yes 2	n 24b. Were au y prior to o ned? death?	topsy findings available completion of cause of second 2 No
Division of Vital spilar or Attending Physician: hours after cleath. neral Director: After this certified in by the funeral director.	25. Was case referred to m examiner? 1 ✓ Yes 2 No. 27. Manner of Death 1 Natural 5 2 ✓ Accident 3 Suicide 6 4 Homicide 29a. Certifier 1 Certify (Check only)	Pending Investigation Could not be determined Graphysician: To the besis and manner.	of Injury Day, Year) 28 29 2006 1. 2006 Major Road st of my knowledge, of examination and/	death occurred a	DOA Ot 28c. Injury a 1 Yes ctory, office built at the time, date	s 2 No Iding, etc. and place, and leath occurred a	g Home 5 F 28d. Describe he Passenger p 28f. Location (St or Town, St Route 273 & due to the cause	Blue Ball Road, I e(s) and manner as star	collision ral Route Number, City Elkton, Md. ted e cause(s)
710	30. Name and address of p Patricia Aronica-F	Pollak MD. Assist	ant Medical Ex		1 Penn Stre	et, Baltimore	e, MD 21201		
Sta Registra			egistrar's Signature	de					
DHMH 17 Rev 1/200 OCME 10/2003	01	_	70	ORIGINAL					

			1 - State Registrar	State of Ma	aryland /	-	artment of I tificate of			giene Reg. No.	36	13232
	Physici /Medic		1. Decedent's Name (First, Middle, Las Dorothy	_{t)} Louise	Smit	h			2. Date of De Month April 8	, Day 2006	Year	3. Time of Death 1:15 A M
	Examir		4a. Facility Name (If not institution, give 2624 Schultz Pla				•	r Location of Dea	ith		nty of Death Charle	S
	Funeral Director		3/9-20-0010	9X 7. Age	e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, 1925	9. Birthp Coun Wash	lace (State or Foreign itry) ington D.C.
	ehow	ō.	Usual Residence of Decedent 10a. State 10b. County		10c. City, To		cation				1	0d. Inside City Limits
	the N	rect	Maryland Charle 10e. Street and Number	25	Waldo	rt	10f. Zip Code			10g. Citizen o	f Whal Cour	
	th with	ai D	2624 Schultz Pla	ce			2060	1		U.S	S.A.	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other then "natural", or items 23s or 28e-f ehow or other treumatic event, the Macical Examination untilled at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub I ☐ Yes 2 No		Specify Yes or No rto Rican, etc.)	- 14. R 8 Spec	ace - Americ lack, White, city: Wh	
ς Ο	72 hor	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16	Sa. Deced	lent's Usual Occup kind of work done OO NOT use retire	pation during most of we	orkina	16b. Kind of	Business/Inc	dustry
Maryland 21215-0036	er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		na ker	d)		Own H	lome	
and	ild be fill lental Hy ked oth Ic event	To Be	17. Father's Name (First, Middle, Last) Joseph L. McGarve	e.y					_{ame (First, Middle,} R. Dakin	Maiden Sum	ame)	
ary	2 shou and M Is mar eumat		19a. Informant's Name/Relationship (7		1		-	and Number or F	Rural Route Numbe			
	1 and Health em 27 ther tr	11/2	Donna L. Curtin/Da	aughter	The state of the s		The second secon	and the second s	, Waldor	f, Mary 20c. Location		
Baltimore,	permit. Pages 1 and 2 Department of Health importent: if item 27 I any injury or other tre		1 🖔 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	Mary		sition (Name of natory or other pla Veterans		18-2006	Chelt	enham,	Maryland
Balt	permit. Depart import any inj		21. Signature of Euneral Service Licen	M0139	1		. Name and Addre		3035 0 POB 156	ld Wash , Waldo	ingto orf, M	n Road D 20604
	Physician		23a. Parti. Enter the disease, or compositions, or heart failure. List only disease or condition resulting in death)	plications that caused one cause on each line	the death. D	o not ente	er the mode of dyin	ng, such as cardia	ac or respiratory a	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	-er		b. Due to (or as a Due to (or a)	mel	ion	nyo Po	they.				
60,	fficate be executed g physician and as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a								
68760	:= C0 m	fedicai		d								
O. Box	The law requires that the death certif ate has been signed by the ettending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	/			Date of delive Month	ry Day Year
ds, P.	ires that I signed by d be deta	b	Part II. Other significant conditions of	ontributing to death but	1	-	1	ren in Part I.				e cause of death?
SCOL	aw require is been si 2 should b	Completed	CHOOLING	003:1000)(1 · C	- 10	018101) = (13 = 10	24a. Was	an 24b	. Were auto	psy findings available
a E	: The lav								autop perfo 1 ☐ Yes	rmed? 28 No	death?	npletion of cause of
=	/siciar s certif directo	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital:	nt 2 EPV	Outpatien	t 3 DOA Ott		eath <i>(Check only o</i> Home 5 Resid		ther (Specifi	4
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The within 24 hours elter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b	Time of Injury	28c. Injur Wor		28d. Describe h			,
Divis	ai or Atte s efter de si Directo ed in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	iry - At home, (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tox		nber or Rura	l Route Number,
	e Hospitai 24 hours e Funerel letely filled	edical (29a. Certifier 1 Certifying Ph	ysician: To the best of iner: On the basis of and manner sta	examination :	lge, death and/or inv	occurred at the tir restigation, in my o	ne, date and place pinion, death occ	e, and due to the surred at the time,	cause(s) and r date and place	nanner as st e, and due to	ated. the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifia	. /			29c. Licens			29d. Date sign		•
		- 1	Pn	2				6478		4-10	06	
M	P 6		30. Name and address of persul who o	completed cause of de	eath (Item 23a	(Type, I	Print)	tts Rel	Clina	ten	MD	20737
3.	Sta Registr		31. Date filed (Month, Day, Year)	32. Register 3 2006	r's Signature	J.	Sperte					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year Physician Ncency C. Staffle

4a. Fecility Name (If hot institution, give street and number) 0244AM Staffler 200€ /Medical 4c. County of Death 4b City Town or Location of Death Examiner NA Baltinore Jer 1 Year If Under 24 Hrs Mary land Medical Cart Jaiversity 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 F NEW JERSEY 155-32-8055 63 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show the Medical Exarciper must be notified at 1 ☐ Yes 2X No **Funeral Director** TALBOT ST. MICHAELS MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21663 USA 904 RIVERVIEW TERRACE Pages 1 and 2 should be filed within 72 hours after death vent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BETTY AILES ပ MARVIN A. KELLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 904 RIVERVIEW TERRACE, ST. MICHAELS, MD 21663 FRANZ STOFFLER/HUSBAND other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 perriit. Page Department of Important: if any injury or once. CHESAPEAKE CREMATION CTR. 4/13/2006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph m. Ostrowsh. C.F.S.P. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner failure ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events onsequence of): Examiner The law requires that the death certificate be executed the burial-transit etiliac resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the e should be detached t o. 9 Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending To the Function after death.

To the Funerel Director: After the function of t 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU 4176435 F16650 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultomore Mo 54 UMMS 22 Si Gree 31. Date filed (Month 2006 32. Registrar's Signature State Registrar

			For State Registrar	State of I	Marylan		artmen rtificat				-	giene Reg. No.	06	13234
, A			1. Decedent's Name (First, Midd	le, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		SARAH	Toc	KER						APRIL	(2006	01:42 V W
	Examin		4a. Facility Name (If not institution	on, give street and number	er)		4b. City,	Town, or	Location o	of Death			ounty of Dea	
46.	39		ANNE ARUNDEL 1					APOL						RUNDEL
	Funeral Director		5. Social Security Number 230-76-9586	6. Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs. 53	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da Sept.	v. Year)		thplace (State or Foreign ountry) rginia
and	*		Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
Jan	f eho	ō	MD Anne	Arunde1	A	nnapol	is							1 ☐ Yes 2 🙀 No
the characteristics	28a	rect	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Co	ountry?
with	3a or	<u> </u>	109 Sunset Dr	ive			2	21403				1	USA	
death	ms 2 Chem	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.	.S. 13.	Was Dece	dent of His	panic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 14.		erican Indian,
after c	or Ite	Fu	1 Never Married 2X Ma	rned 1 Yes 2		i	ii tes,spe 1 □ Yes		Specify:		nican, etc.)		Black, Whit	
Sino	Exe	d by	3 Widowed 4 Divorce	d If Yes, Give Year or Date	s:		103	ZALL INU	эрвспу.			3),	pecify: M	Thite
d C I C I 3-0000 filed within 72 hours after death with the Maryland	natu	Completed		nt's Education est grade completed)		16a. Dece (Give	kind of wo	rk done di	urina mos	t of worki	ng	16b. Kind	of Business	/Industry
vithin	han A Ma	ш	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT u					F100	r Cove	rings
1 Pe	her t		17. Father's Name (First, Middle	2		Bookk	eepei	1	18 Mothe	ar's Name	(First, Middle			IIIIgs
be d	od of	Be	Guy L. Wingo,								laddox	Walder St	mamo,	
hould	d Me nark natic	ပ	19a. Informant's Name/Relation			19h Maili	na Address	(Street a			I Route Numb	ar City or T	own State	Zin Code)
WIG d 2 s	th an 17 is 1		James Tucker								olis,	-		<i>C.P GGGG</i>
ָהַ בַּ	Heal tem 2		20a. Method of Disposition	(naobana)	20b. P	Place of Dispo					ate			Town, State
2 2	it: # i		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (TO				ì	4-10	2006	Anna	polis,	MD
	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f ehow Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Executive freeling and once.		21. Signature of Funeral Service								Home,		PO L 13,	1115
	Depa Impo any ir		1 3	9			Haro	lesty Ridge	Fune	eral enue.	Home, Annap	P.A. olis.	MD 21	401
: A ^r .	E Sa		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cau	sed the deat	h. Do not ent								Approximate Interval Between
PI	hysician		Immediate Cause (Final	-	CNARY	, 12	MISC							Onset and Death
	Medical		disease or condition resulting in death)	a	as a conseq		-4150	1.05						, , , , , , , , , , , , , , , , , , , ,
E P	xaminer		Conventialty list and dising	, Non-	SMAL	L Ct	=	4	016	ι	CANCE	EK		
D	æ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):								
acute	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C										
e be executed	cian a	Ē	7000/m/g // 004// 2200	Due to (or	as a conseq	uerice or):								
Cate	certificate has been signed by the ettending physician and rector, page 2 should be detached for use as the burial-transit	dical		d										
Sertifi C	ding	Physician/Med	IF FEMALE:	23c. If yes, outcome	me of preans	ancv		-				230	d. Date of de	livent
dath C	etter I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnan	2 Feta	death 3[Ectopic p Other (sp					200	Month	Day Year
; §	y the	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknow										
, Lhat	ned b	by Pi	Part II. Other significant condit	ions contributing to deat	h but not res	ulting in the u	nderlying o	ause give	n in Part I		23e. Did t	obacco use	contribute to	o the cause of death?
	n sig										18	Yes 2□I	No 3 P	robably 4 Unknown
	s bee 2 sho	Completed									24a. Was		24b. Were a	utopsy findings available completion of cause of
i ed	ite ha	E									auto perfo	rmed?_	death?	
<u> </u>	rtifice Xor, p	BeC	25. Was case referred to medic	al					26. Place	of Death	(Check only			
> 1	direc	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1np		EP/Outpatier	nt 3 🗆 D	Othe	r: 4 □ Nu	ursing Ho	ne 5□Resi	dence 6	Other (Spe	ocify)
ding Ph	After this certificate ha		27. Manner of Death 1 ☑Natural 5 ☐ Pend	28a. Date of (Month,	njury Day Yea <i>r)</i>	28b. Time o Injury	1 :	28c. Injury Work	at ?		28d. Describe			
2 5	eath. or: A the fu	catle	2 Accident inves	tigation			М		′es 2 🗆					
Lor All	after d Direct	Certification;		mined 288. Place of	Injury - At he etc. (Specif	ome, farm, st fy)	reet, factor	y, office			28f. Location (City or To		Number or R	u <i>ral Route Number</i> ,
DIVISION OF VICE DECOMES, F.C. BOX 991	within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical C		ing Physician: To the be if Examiner: On the basi and manner	s of examina									
the	within To the	Me	29b. Signature and title of certif				29	c. License	number			29d. Date s	signed (Mon	th. Day, Year)
-	>= 0		Drien E	IN PEOU	D		7	000	617-	76		APIZIL	ا ما ا	2006
			30. Name and address of perso		of death (Item	n 23a) (Type,	Print)		_					
	1		BRIAN WOLF, MA	110 DEF				re 4	00,	Ann	APOLIS,	MARY	DUAND	21401
	Sta Registr		31. Date filed (Month, Day, Yea			ature								

DHMH 17 Rev 1/2001

Registrar

1.1 2006

			1 :	For State Registrar		State of M	aryıan			nt of H		na Mei		giene Reg. No	- U U	16	13236
	Physici			cedent's Name	(First, Middle, L	Dorothy			True	tt			Date of Dea Month pril (Da	2006	Year	3. Time of Death 8:15 p M
	/Medio Examir		4a. F	ecility Name (If	not institution, g	ive street and number)					Location of I		<u> </u>	$\overline{}$. County	of Death	<u> </u>
		•		Heritage	e Harbo	ur Health &	Reh	ab.	Ar	napo1	is			A	nne	Arun	ide1
	Funeral Director		5. So	71-22-3	mber 6.			last birthday) Yrs.		er 1 Year	If Under 24	Hrs. 8.	Date of Birt (Month, Day eb. 20			9. Birthi	place (State or Foreign ntry)
	land ow			af Residence of I	Decedent 10b. County		10c. Cit	y, Town or Lo	ocation								10d. Inside City Limits
	Many a-f-sh	ţo]	MD	Anne A	rundel		Annapo	lis								XX Yes 2 ☐ No
	or 28¢	Director	10e.	Street and Num	ber				10f. 2	ip Code				10g. Ci	tizen of V	Vhat Cou	ntry?
	23a vi	a	1	8 Steel	e Avenu	e				214	01				USA		
	ep E	nei	11. N	Aarital Status		12. Was Decedent Armed Forces?	Ever in U.	.S. 13.	Was Dec	edent of Hi	spanic Origir n, Mexican, I	n? (Specify	Yes or No-			e - Ameri k, White,	can Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland It of Health and Mental Hygiene. If Item 27 ie marked other than "natural", or items 23a or 28s-1 ehow or other traumatic event, the Medical Exacultual be trutified at	Completed by Funeral		☐ Never Marrie ☐ Widowed 4				ŀ		2 X XN0	Specify:		un, 010.7		Specify		hite
5-0	72 ho	eted		(Specif	15. Decedent's	Education trade completed)		16a. Dece	dent's Us	ual Occupa	ition uring most o	of working		16b. K	(ind of Bu	siness/In	ndustry
21	han "	d d	Efe	ementary/Secon		College (1-4or	5+)								4.1		
	filed withi Hygiene. other than		17 E	ather's Name (F	First Middle La	4		Nurse	Ane	sthet	1St 18. Mother's	e Namo /E	imt Middle		alth		'e
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than surmatic event, the Mi) Be		enry Li		st/							rrmanı		i Sumam	e /	
<u> </u>	should be fand Mental is marked of marked of inmatic even	ပ္		Informant's Nar		(Type, Print)		19b. Maifir	na Addre	ss (Street a	nd Number				or Town.	State. Ziu	c Code)
Ma	nd 2 :		J	ames W.	Truett	, Jr. (Hush	and)		-		nue, A						
ē,	S 1 a of Height		20a.	Method of Dispo	osition		20b. P	face of Dispo	sition (A	ame of	9)	Date		20c. L	ocation -	City or To	own, State
Ē	Page nant o			1 XBurial 2 ☐ 4 ☐ Donation 5		☐Removal from State cify)		yland				-14-2	006	Cro	wnsv	ille	, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: if item 27 ie any injury or other trau once.		21. 5	Signature of Fun	eral Prvice Lic	alsap -		22			Funer Funer					m 21	۸ 0 1
			23a.	. Part1. Enter the	e disease, or co	mplications that cause by one cause on each li	d the death	n. Do not ent							Π و ۵.	D 21	Approximate Interval Between
	Physician /Medical		Imm	nediate Cause (F ase or condition alting in death)	inal	a. Onge Due fo for as	twe	Hee	ret	Fau	lure						Onset and Death
	Examiner		Sequ	uentially list con-	ditions,	b				· · · · · · · · · · · · · · · · · · ·	- <u></u>						
	cuted	Examiner	caus Caus that	uentially list con- y, leading to immode. Enter Underlise (Disease or in initiated events	nediate lying nury	Due to (or as	a consequ	uence or):									
68760,	tificate be executed g physicien and as the burial-transit		resul	lting in death) La	ast	Due to (or as	a consequ	uence of):									
687	ificate g phy: as the	edlcal				d											
O. Box	eath cer attendin for use	Physician/M	23b.	EMALE: Was decedent in the past 12 n 1 Yes 2 1 9 Unknown	nonths?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3	Ectopic Other (pregnancy specify)					23d. Date Mor		ery Day Year
P.O	uires thet the d signed by the d be detached		Part I	II. Dther signific	cant conditions	contributing to death b	out not resi	ufting in the u	nderlying	cause give	n in Part I.		23e. Did to	bacco	use contr	ibute to t	he cause of death?
ords	w requires been sign should be	ted by	_									_	1 🗆 Y	es 2	□ No	3 🗌 Prot	pably 4 Sunknown
Records,	Physician: The law r this certificate hes be al director, page 2 sh	Completed										_	24a. Was a autop perfor	sy med?	a P	Vere auto rior to co leath? Yes	opsy findings available impletion of cause of 2 💆 No
Vital	ilcian: Th certificate rector, pag	Be		Was case referre	ed to medical							Death (C	heck only o	ne)			
5	Physic this o	၉	1	☐Yes 2N	10	Hospital: 1 Inpati		ER/Outpatier			4 D Nursi		5 Resid				5)
ion	fe fe	atlon:	1	Manner of Death Natural Control	5 Pending investigate	28a. Date of Inju (Month, Da	ry Year)	28b. Time of Injury	M	28c. fnjury Work 1 🔲 \	at ′ ? ′es 2∐No		. Describe h	ow infu	ry occurre	ed	
Division	Hospital or Attending Physician: 4 hours effer death. Funeral Director: After this certification by the funeral director.	Certification:		3 Suicide 4 Homicide	6 Could not determine	28e. Place of fn building, et	jury - At ho c. <i>(Specif</i>)	ome, farm, str	eet, facto	ry, office		28f.	Location (S City or Tow			er or Rura	al Route Number,
	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	Medical (29a.	Certifier (Check only one)	Certifying	Physician: To the best aminar: On the basis of and manner st	f examina	wledge, death tion and/or in	occurre vestigation	d at the time in, in my op	e, date and a inion, death	place, and occurred a	due to the o	ause(s) and mar d place, a	nner as s and due to	stated. the cause(s)
	To the within To the comp	ž	29b.	Signature and ti	itle of certifie	1			2	9c. License	number			29d. Da	te signed	(Month,	Day, Year)
					2//	1				038	958	>		4/	10/	06	
			30. N	vame and address	ss of pluson wh	o completed cause of	death (Item	23a) (Type,	Print)	in t	110/10	nu l	C. Por	Bi	1 Vnd	· M	1021061
	Sta Registr		31. [Date filed Month	APR 11	2006 32. Jegista	rar's Signa	ture	Soul		U	1			1 - 110		~ · · · · · · · · · · · · · · · · · · ·

06-02547 John Tierney

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

(1)		0	1	6	0	0	
1	U	11	6	.)	1	3	

	1- For State Registrar		Certific	ate of	Death			Reg. No.	40	00 19591
Physician/ ledical Examiner	Decedent's Name (First, Midd	John Ph	illip T	'iern	ey		2. Date of Month April 1		Year	3. Time of Death 1245 hrs
	4a. Facility Name (if not institution Southern Maryland Ho			41	o. City, Town, or L Clinton	ocation of [Death		County of	
Funeral Director	5. Social Security Number 214-78-3305	6. Sex 7. Age	(In yrs. last bin	thday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	of Birth (MM/I		Birthplace (State or Foreign Country) Wash DC
Maryland 288-f show any d at once. ector	Usual Residence of Decedent 10a State 10b. County Marral and Drin		10c. City, Town	or Locatio			рерс		LJ02	10d Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f she notified at once	Maryland Prin 10e. Street and Number 5400 Farrag				Hyattsv 10f. Zip Code	7111e 9.781		10g Citiz		at Country?
or items must be Funera	11. Marital Status 1 XNever Married 2 M	12. Was Decedent I arried Armed Forces?	Ever in U.S.	If Ye	Decedent of Hisps, specify Cuban,	anıc Origin' Mexican, P)		- American Indian, Black,
21215-0036 It be filed within 72 hours after dental Hygiene. narked other than "natural", event, the <u>Medical Examiner</u> o Be Completed by I	15. Decedent's Education (Spe Elementary/Secondary (0-12) 9th	cify only highest grade com College (1-4 or 5		during mo	s Usual Occupation st of working life. I	DO NOT us	se retired)	16b. K		ivate
21215-0036 uld be filed within 7 marked other than event, the Medica	17 Father's Name (First, Middle Louis Tier	ney	1			Ann	Name (First, Mid a Kande	tzki	·	
MD 21 12 should th and Me 127 is ma unmatic ev	19a. Informant's Name/Relations Sharon Kroten				Address (Street Delight					i, State, Zip Code)
	20a, Method of Disposition 1 X Burial 2 Cremation 4 Defation 5 Other S	pecify	te cremat	tory or other	ln Cemet	ery 4		6 F	3rent	City or Town, State
Balti permit Departin Importi injury c	21. Sil ature uneral Service	nsee M/			ame and Address of 13 Annap					
Physician /Medical ¬xaminer	3a. Part I. Enter the dise of failure. List only be cause Immediate Cause (Final disease or condition resulting in death)	on each line.	ns of alo						ck, or hear	rt Approximate Interval Between Onset and Death
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a conse	quence of):							
cuted and transit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	,							
8760, tificate be executed ng physician and as the burial - transit	X UNPENDED	AMENDED item 23c. If yes, outcom		28a-f,	perMe,g855	, 5/26/0)6 TT	23d	. Date of c	delivery
a la si a la ci co	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	ne 1 Live birth		2 Feta 5 Oth	al death 3 er (Specify)	Ectopic pr	regnancy		Month	Day Year
cords, P.O. B law requires that the d has been signed by the 2 should be detached orpleted by Phy	Part II. Other significant condit	tions contributing to death	but not resultin	g in the un	derlying cause giv	ven in Part I			_	oute to the cause of death? Probably 4 Unknown
							a	Vas an utopsy erformed? 'es 2 No	pr de	vere autopsy findings available for to completion of cause of eath?
tal Recian: The certificate ector, page	25. Was case referred to medical examiner?	- Hospital:			10		heck only one)			
of Vit ing Physic After this funeral dire	1 Yes 2 No	Hospital: 1 Inpatier 28a. Date of Injur	nt 2 V ER/O	utpatient Time of In			Jursing Home 5	Resider		Other:
Division o spital or Attending rours after death nertal Director: Aft filled in by the fune Certification:	1 Natural 5 Pen	ding stigation Fnd 2/19/2	9006 unk	ζ	1 Ye	es 2X N	o unk			
Divi spital or / lours after neral Dire filled in E	4 Homicide	id not be	und in cl		, factory, office bu	ilding, etc.	or Toy	on (Street ar vn. State) S burg ,		r or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the Medical Certificati	one) 2 Medical Exa	hysician: To the best of my iminer:On the basis of exam and manner stated								
¥	29b. Signature and title of certific				29c. License O.C.N				ate signe I 15, 200	d (Month, Day, Year) 06
RO	30. Name and address of persor Ling Li, MD Assista	who completed cause of de ant Medical Examiner	,	n Street	, Baltimore, M	1D 21201	1			
State Registrar			s Signature	Age	de la company de					

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

intothy Lytin V	-	1- For State Registrar	e or iviaryianu /		ificate of		iù ivieii	lai i iyyie		g. No.	006	13238
Physici		Decedent's Name (First, Middle,L	·				•	2. Da	te of Death		'ear	3. Time of Death
Medical Exami	ner	4a. Facility Name (if not institution, o	Cimothy Lyni	n Vog		o. City, Town, or	r I ocation o	Ap of Death	ril 17, 20	006	y of Death	1025 hrs
		54 Coachman Drive	, vo on our and names,			Rising Sun	Location	or Boutin		Cecil	y or beatin	'
Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. las	t birthday)	If Under 1 Year Months Day			Date of Birth	(MM/DD/YY	YY) 9. Birt Foreig	thplace (State or
Director			XM 2 F 4	5	Yrs.	World Bay	75 Hours	J	une 3	, 1960	Cou	^{untry} Michigan
any		Usual Residence of Decedent 10a. State 10b. County	·	I0c. City, T	own or Locatio	n						10d. Inside City Limits
	ō	Maryland Cecil		E1k	ton							1 Yes 2 X No
Maryl r 28a-1 ed at o	Director	10e. Street and Number				10f. Zip Code			10	g Citizen of \	What Cour	ntry?
ith the	al Di	291 Sycamore Roa	12. Was Decedent E	avos in II S	112 10/00	21921	na ania Osia	:=2 / C===if. \		United		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she after event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Marrie	Armed Forces?	No No		Decedent of His s, specify Cubar	n, Mexican,	Puerto Rican	, etc.)		ce - Americ nite, etc.	can Indian, Black,
after c	by F		ed If Yes, Give Year 19	77	_	res 2 X No				Specify	Whi	te
hours "natur		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade comp College (1-4 or 5-			s Usual Occupa st of working life			one	16b. Kind of I	3usiness/Ir	ndustry
036 thin 72 ne. than edical	Completed	12	College (1-4 of 3	'	P1umbe	r				New	Cons	truction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, La	*					s Name (First		aiden Surnan		
2121 Ild be f Mental market event,	To Be	Harold James Vog			19b Mailing	Address (Stree		y Jean			State State	Zin Codo)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	-	Cheryl A. Vogel		- 0		camore						
re, legal stranger transcertran	Ì	20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from Stat		ace of Disposit	on (Name of ce	metery,	April	19.	20c. Location	n - City or Ches	Town, State
Baltimore, permit Pages I an Department of Hee Important: If ite		4 Donation 5 Other Speci	fy.			& Co. Inc		2006		Penn	sylva	ania
Baltimore permit Pages I Department of F Important: If i		21. Si nature of Funeral Service Lic	ensee		Hic Hic	me and Address	s of Facility for	Funera	1s, P	, A.	M	land 21921
Physician		23a. Part I. Enter the disease, or cor failure. List only one cause on		ne death. D	o not enter the	mode of dying	such as ca	I SLIEE ardiac or respi	ratory arres	KTON, st, shock, or h	Mary. neart	Approximate Interval
/Medical √ €xaminer		Immediate Cause (Final disease	Atheroscle	rotic c	cardiovas	cular dis	sease					Between Onset and Death
		or condition resulting in death)	Due to (or as a consec	quence of):								
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):								
4	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):								
.760, ficate be executed g physician and the burial - transit	- 1		d	#00) 7 N/III	056.6.60	/oc IIII					
760, icate be ex g physician the burial	Medical	X UNPENDED	AMENDED ite			g850,6/8/	/06 TT			Too : B :		
6876 certifica nding ph	ician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		2 Feta	I death 3	Ectopic	pregnancy		23d Date Month		ay Year
Box 687 The death certification of the attending properties of the asternation of the attending properties of the	<u></u> I	1 Yes 2 No 9 Unknow	vn 9 Unknown	me of death	h 5 Othe	er (Specify)						
that the d	/ Phy	Part II. Other significant conditions	contributing to death	but not resi	ulting in the un	derlying cause	given in Pa	rt I 2	3e. Did tob	acco use con	tribute to t	the cause of death?
s, P.O. uires that the signed by id be detach	ed by						-	_ 1			3 Proba	abiy 4 Unknown
cords, law requir has been s	Completed							2	4a Was ar autopsy	/	prior to co	opsy findings available ompletion of cause of
tal Rec cian: The l certificate bector, page	Com								perform ✓ Yes 2		death?	s 2 No
of Vital Records, ng Physician: The law requir wfer this certificate has been s neral director, page 2 should t	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatien	1 2 F	R/Outpatient		Other	Check only or Nursing Hom		esidence 6	Other	Scene
ing Phy After th	ان ا	1 V Yes 2 No 27. Manner of Death	28a Date of Injury (Month, Day,Yea	/ 2	8b. Time of Inj		ry at Work			w injury occu		. doene
sion ttendii death. ctor: /	atio	1 X Natural 5 Pending 2 Accident Investiga				1	Yes 2	No				
Division pital or Attendio ours after death, teral Director: A	ertification:	3 Suicide 6 Could no determin		ry - At hom	ne, farm, street,	factory, office t	ouilding, etc		ocation (Sti r Town, Sta		ber or Rur	al Route Number, City
Hospit Hospit Eu hour Funera	ပ	4 Homicide	cian: To the best of my	knowledge.	. death occurre	d at the time. d	ate and pla	ce. and due to	the cause	(s) and mann	er as starti	ed .
Division of Vital Records, P.O. Box 68' Within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certification or Attending Physician and I have after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical		er:On the basis of exam and manner stated									
	Σ	29b. Signature and little of certilier		1		29c. Licens			- 1			th, Day, Year)
		20. Name and address of across		ath (line 6)	20)	O.C.	IVI.∟.			April 18, 2	.006	
		30 Name and address of person who Susan Hogan MD. Ass	sistant Medical Exa		•	Street, Balt	timore, M	/ID 21201				
	ate	31. Date filed (Mapth Ray Year)	006 32 Registrar's	100	Land	50						
Regis	rar	0 2	UUU JAMARA	1 15	1	14						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 11:36A M Louise Watkins 04 03 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F 78 Yrs 228-28-5627 Director 08 08 Hopewell, VA Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ui Hygiene. other then "natural", or items 23e or 28e-f show vent. tre Medical Examinar must be notified at 1.□Yes 2□No MDMontgomery Directo Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11101 Georgia Ave. #505 20902 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21K No Specify: Black Specify: δ 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Provider Self Employed permit. Pages 1 end 2 should be file. Department of Health and Mental Hyg Important: If Itsm 27 is marked other sny Injury or other traumant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William W. Brooks Louise Reaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa A. McGill/Daughter 11101 Georgia Ave. #505 Wheaton, MD. 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cem. 04-08-06 Brentwood, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 4217 9th. St. N.W. Washington, D.C. sha 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lumor **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the e e detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signi page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1□ Yes 1 Tes No No After this certification funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 25 No 1 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Dole of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the nours effer death.

To the Funeral Director; Aff 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cauca(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29s Certifier Medical (Check only one) the L 29b. Signature and title of certifier-29c. License number ٥ 29d. Date signed (Month, Day, Year), 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road oneyir NEG CNOSO 111.00 Silver Spring, MD. 20910 31. Date filed (Month, Day, Year)/ 32. Registrar's Signature State APR 1 2 2006 Registrar

		-	For State Registrar	State of M	faryland	-	artment of H			R	eg. No.	6	13240
	Physicia		1. Decedent's Name (First, Middle,	-						Date of Dear Month	Day	Year	3. Time of Death
	/Medic	al	Rodie	Wayne			Weber			April	5 200		1:30 p ^M
1	Examin	er	4a. Facility Name (If not institution,		r)		4b. City, Town, o		of Death		4c. County		
			4 Breakwater C 5. Social Security Number		Age (In yrs. I	ast hirthday)	Pasade	na If Under	24 Hrs. 8	Date of Birth	Anne		
	Funeral Director		220-66-1215	X 2□ F	49	Yrs.	Months Days	Hours	Min.	(Month, Day	2,1956	Eng	place (State or Foreign ntry) land
			Usual Residence of Decedent							agase	2,100		
	nylan how		10a. State 10b. County			r, Town or Lo							10d. Inside City Limits
	Ba-f	cto		Arundel	H	Pasade							1 ☐ Yes 2√√XNo
	vith th	Funeral Director	10e. Street and Number				10f. Zip Code			1	Og. Citizen of W		intry?
	s 23s	ra	4 Breakwater C	Ourt 12. Was Deceder	t Ever in III	S 13		21122	igin? (Specif	v Yas or No-	US.		can Indian,
	ter de Item	ä	11. Marital Status 1XXVever Married 2 Marrie	Armed Forces	s?		Was Decedent of H f Yes, specify Cuba	an, Mexicar	n, Puerto Rio	an, etc.)		k, While	
936	urs at	ğ	3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 X If Yes, Give Year or Dates	37.		1 ☐ Yes 2 2 No	Specify:			Specify	· W	hite
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. de Hygiene. de other then "natural", or items 23a or 28a-f ehow de other then "natural", or items 23a or 28a-f ehow event, Ite Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occup	ation	at of working		16b. Kind of Bu	siness/lr	ndustry
21	ithin 1	nple	Elementary/Secondary (0-12)	College (1-40	r 5+)		kind of work done DO NOT use retired	d)			D 11	_	
N	ygier ygier her th		11 17. Father's Name (First, Middle, Li	4)		Tec	hnician	19 Moth	or's Name /F	First Middle	Radio Maiden Sumam		r
and	ntal H	Be		151/						Martin		5)	
Maryland	s 1 and 2 should be filed within I Health and Mental Hygiene. Item 27 is marked other then " other traumatic event, I'm Me.	P P	George Weber 19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	na Address (Street					State, Zi	p Code)
Ma	trau		Barbara Weber			1280	4 Holiday	Lane	e, Bow	ie, MD	20716		
ē,	Hear Hear other		20a. Method of Disposition		20b. P		osition (Name of matory or other place		Date		20c. Location -	City or T	own, State
ê E	Page: ent o nt: #		1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe		l u		ematory		4/10/	2006	Baltim	ore,	MD
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 it any Injury or othar tra		21. Signature of Funeral Service Li	censee 70	'		Name and Addre Hardesty	ss of Facili	ity	ome P	Δ		
m	Depermine the permine	175 %.	Com			12 Ridge	ly Av	zenue,	Annap	olis, M	D 21	401	
	Physician /Medical Examiner iual-transit	Examiner	23a. Part1. Enter the disease, or cannot shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence as a c	uence of):	Lympl						Interval Between Onset and Death MOS
P.O. Box 68760,	iries thet the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 ☐ Fetal at time of d	Ideath 3[□Ectopic pregnance □ Other (specify) _	у			23d. Dat Moi	nth	Day Year
Records, F	The law requires thet the ste has been signed by the bage 2 should be detache	۵	Part II. Other significant condition	C CIVVIA	o SIS	ulting in the c	inderlying cause giv	ven in Part	l. 	23e. Did to	473	ribute to 3 ☐ Pro	the cause of death?
000	aw requir is been si 2 should l	Completed	arvourc	hepati)	77	10				24a. Was autop			topsy findings available ompletion of cause of
æ	: The law cete hes t page 2 s	E								perfor	med?	death?	2 No
Vital	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?						e of Death	Check only o	ne)		
<u>></u>	Physicien: this certific ral director,	2	1 ☐ Yes 2 No			ER/Outpatie	nt 3 DOA				ence 6 Oth		in) Sister's
Ē	fe fe	i o	27. Manner of Death 1 Natural 5 ☐ Pending		njury Day Year)	28b. Time of Injury	Wo			d. Describe h	ow injury occurr	ed	
Division of	Attending I or death. ector: After by the funer	Certification:	2 Accident investigation investigation Accident 6 Could not be a suicide 6 Could not be a suicide as a suicid	ot be 390 Blace of	Injunt - At he	ome farm st	M 1 reet, factory, office	Yes 2		f Location (S	Street and Numb	er or Ru	ral Route Number,
Οį	or A efter Direction by	ertif	4 Homicide determin	building,	etc. (Specif	y)	reet, raciory, onice			City or Tow			
_	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical C	23a. Cartifor (Check only one)	Physician: To the be examiner: On the basis and manner	s of examina	wiedge dat ition and/or in	th preumad at the ti restigation, in my o	ma date a opinion, de	nd place, an ath occurred	d-dua to the o at the time, o	ausa(s) and ma date and place,	nner as	to the cause(s)
	vithin o the omple	Me	29b. Signature and little of certifier	- 1			29c. Licen	se number			29d. Date signe	d (Month	, Day, Year)
	->-0		> 7. #ll	only	10			48.	58		41	5	4006
			30. Name and address of person v	who completed cause of		n 23a) (Type	PrinI) R	est	gate	Rd. 1	7 nuapo	ilis	Mid.
	St	ate	31. Date filed (Month, Day, Year)	32 F leg	istrar's Signa	ature	1 20						
1	Regist		APR 11	2006	THE S	J. 1							

tay as not me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 7, April 2006 10:09AM SUZANNE WILKINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Months Yrs 52 Jun23,1953 Director 577-74-0001 Arizona Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits other then "neturel", or items 23s or 28s-f show rent, the Medical Examiner must be notified at MD Forrestville Prince George 1 XYes 2 No Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20747 5809 Marlboro Pike U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "neturel", or Items 23s any injury or other traumatic event, the Medical Examiner must one. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ②No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify þ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Agent Allstate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George D. Young Cleo Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Walker Mill Rd Capitol Heights, MD20743 Ronnie Ryland- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Ressurection Cem 4/13/06 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 9 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer **Physician** /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit Due to (or as a consequence of) Physician/Medical as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificete 2 XIO 1 ☐ Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Impatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending M□ Natural investigation 1 Yes 2 No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. death. Director: / To the Hospital or At within 24 hours effer d To the Funeral Direct completely filled in by

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Day, Year)

29b Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

6 ☐ Could not be

determined

29c. License number D41752

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

April 10, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 1500 Forrest Glen Dr Silver Spring, MD 20910 Bergit Schollmann, 31. Date filed (Month

State Registrar

Medical

12:42

Approximate Interval

Between Onset and

Death

Year

2 No

28d. Describe how injury occurred

Operator of motorcycle in collision

or Town, State) Route 273 @ Blueball Rd, Elkton, MD

April 10, 2006

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

this certificate h ...ospital or Attending Physician: Th thin 24 hours after death. 'he Funeral Director: Africately filled in be-To the 1

0 +IVA

State Registrar

Certification:

one)

1 🗸 Yes

27 Manner of Death

Natural

Suicide

Homicide

29b. Signature and title of certifier

2 Accident

5 Pending

Investigation

Could not be

Patricia Aronica-Pollak MD. Assistant Medical Examiner (Month, Dav, Year, 32. Registrar's Signatur 2 2006

30. Name and address of person who completed cause of death (Item 23a)

28a. Date of Injury (Month, Day, Year) Apr 9, 2006

and manner stated

(Specify) Major Road

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number O.C.M.E.

Yes 2 V No

ORIGINAL

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

12:39

DHMH 17 Rev 1/2001 OCMF 10/2003

			For State	State of Ma	aryland / De	partmer e <i>rtificat</i>				_	600	5	13243
	2.8 a	Ŷ	Registrar 1. Decedent's Name (First, Middle, Lasi	")		ortinoat	0 0/ 1	Journ		Date of De.			3. Time of Death
	Physicia	_	MARY EMILIE WRI	GHT						Month	Day	2006	0100 M
0	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	A company	Location o			4c. County	- 11	-
		Ш	Nemorial + 5. Social Security Number 6. Se	OSPITAL 7. AO	je (In yrs. last birthda	y) If Under	r 1 Year	Stor		. Date of Birl		9. Birthp	
	Funeral Director		148-03-1829	X	89 Yrs.	Months	Days	Hours	Min.	Date of Bird (Month, Da JUL 25	1916	NEW NEW	lace (State or Foreign itry) JERSEY
	pu		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	Location				-, <u>-</u>			0d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show Entrast for collined at	ō	MD CAROL	TNE	PRES								1 X)Yes 2 □ No
	r 28a-	Director	10e. Street and Number	TME	FRE		o Code				10g. Citizen of \	What Cour	ntry?
	th with	alD	105 CAROLIN COUR	r			2165	55				USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		3. Was Dece II Yes, spe	dent of Hi orfy Cuba	lispanic Ori an, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No can, etc.)		ce - Americ ck, White,	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔣 If Yes, Give Year or Dates:	No	1 🗆 Yes	2 X i No	Specify:			Specify	v: WHI	TE
500	2 hou		15. Decedent's Ed	ucation	16a. De	cedent's Usu	al Occupa	ation	et of working	,	16b. Kind of B	usiness/în	dustry
Wright 121215-00	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	life	DO NOT	ise retired	during mos d)	a or working	,			
3 2	led wi tygien her th		12. Father's Name (First, Middle, Last)	0	J	HOMEMAI	KER	18 Moths	er's Name /	First Middle	OWN Maiden Suman	HOME	
Waryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinating that be coulded at Once.	To Be	GARDNER JONES							E. VAN		.07	
ary T	2 shou and M Is mar aumst	2 0	19a. Informant's Name/Relationship (7			-					er, City or Town,		
	1 and Health em 27 ther tr		ROBERT G. WADDING 20a. Method of Disposition	GTON/PER.	20b. Place of Dis	sposition /Na	me of	1	D, PI.		VE, NJ		
Mary Baltimore, Mi	Pages ent of I nt: If ite y or of		1 ☐ Burial 2 ★ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		comotoni i	rematory or	other plac	1	TR 4/	12/200		•	
altii	permit. F Departme Importar any injur		21. Signature of Funeral Service Licen		1	22. Name a	nd Addres	ss of Facili	ty		AM FUNE		
_	80 = 8		15/10	lane		200 S.	HARI	RISON	ST E	ASTON,	MD 216		
			23d. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each li	d the death. Do not ine.	enter the mo				respiratory a			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.END		E	C	08			JULTINE	BNLY	wommer.
	Examiner				a consequence of):	one	200	VEV	m 0	NID	-		
_		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):								
	ocuted nd transil	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence ol):								
387	physicate b	dlcal	•	d									
Box 6	auth certifii attending p for use as	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Da	ate ol delive	əry
m.	ne death the atte	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No			3 □Ectopic p 5 □ Other (s		y 			Mo	onth	Day Year
P.O	that the de ed by the detached	Phys	9 ☐ Unknown Part II. Other significant conditions o					on in Dark	t .	230 Did t	tobacco use con	tribute to t	he cause of death?
Division of Vital Records, P.O.	signed d be del	Completed by Physiclan/Me	HORER TE		•	e underlying	cause givi	ren in Fait	ι,		Yes 2 □ No	3 Prob	
Ö	v requir been s should	etec								24a. Was	an 24b.	Were auto	ppsy findings available
Re	he tav e has age 2	dmc								auto	psy ormed?	prior to co death? 1 Yes	mpletion of cause of
Ta Ta	ician: Th certificete ector, pag	BeC	25. Was case referred to medical					26. Place	e of Death	1 ☐ Yes Check only		10 103	Aire
<u>></u>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpati	ient 2 🗆 ER/Outpa				ursing Hom	e 5 ☐ Resi	idence 6 Oth	ner (Specil	(y)
0	ding Physician: The lav n. After this certificete has funeral director, page 2	.: 0	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Tim ay Year) Inju		28c. Injun Wor	ry at		3d. Describe	how injury occur	red	
isio	tendi death. tor: A	icat	2 Accident investigation 3 Suicide 6 Could not be		njury - At home, Jarm,	M street facto		Yes 2		Rf Location (Street and Num	ber or Run	al Route Number,
Div	of or Attending after death. Director: Al	Certification:	4 Homicide determined	building, e	tc. (Specify)	311001, 12010	ry, onice			City or To			
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the		(Check only 2 Medical Exam	niner: On the basis of	t of my knowledge, d of examination and/o	eath occurred	d at the tin	me, date ar opinion, dea	nd place, ar ath occurre	nd due to the	cause(s) and m date and place,	anner as s and due t	stated. o the cause(s)
	thin 24 the F the F mplete	Medical	one) 29b. Signature and title of certifier	and manner s	tated.			se number			29d. Date signe		
	F \$ F 8) COD	2	ms	r) L	3	1-7	V	04,12	. 0	6
	1D		30. Nam and Addings of 660 M	cd NI NA sek	dem (Iter A 1) y	pe, Print)	<u>ノ (</u>	ر ر		9			
					trar's Signatur	219	S. WA	ASHIN	GTON	ST., E	ASTON, I	MD 21	601
	Sta Regist	ate rar	31. Date liled (Month, Day, Year) APR 13	2006	you A	Sec.	10						

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Rag. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year Physician Nancy Jane Wood 2006 ድ 4,25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21804 WICOMICO SALISBURY REHAB & NURSING CENTER SALISBURY, MD. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/26/1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 220-12-0890 80 Director Maryland Usual Residence of Decedent Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exaction round by notified at ty⊡Yes 2 □ No Maryland Wicomico Director Salisbury the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 203 Holland Ave. 21804 LISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: If Yes, Give Year or Dates: white 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smiley B. Haddock Jennie Foskey ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melody J. Wood/daughter PO Box 35, Fruitland, MD 21826 if Health item 27 I 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State important: If it any injury or o once. Springhill Memory 1 Burial 2 Cremation 3 Removal from State 4/12/06 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association CFSP Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse ence of): Examiner 0 Squentially list on diffusion if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0 · 6000-Due to (or as a nsequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit ear-20 o (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 Yes 2 10 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 Yes 2 40 Division of Vital Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examines Hospitaf: 1 ☐ Inpatient Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 () NO 2 ER/Outpatient 3 DOA in s After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 L Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 12 2006

Vancy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 18, 2006 Physician Μ. Walton Kathleen 4:30 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 1106 Elkhart Street Oxon Hill
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, March 15, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min Y 1953 Washington, DC 1 M 2 XXF Yrs. Director 212-66-6897 53 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County il Hygiene. other then "natural", or Items 23a or 28a-f show vent, the Madical Examinar must be notified at 1 ☐ Yes XX No Director Prince George's Oxon Hill Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 1106 Elkhart Street USA death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes AND Specify: White 3 ☐ Widowed 4 🙀 Pivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Computer Technician Custom Cable permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Item 27 is marked other if eny injury or other traumatic event, the ODGS. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank J. Panetta Sr. Mary T. Slivinsky ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1106 Elkhart Street Oxon Hill, Maryland Mary T. Panetta / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/19/2006 Kalas Crematory Edgewater, Maryland 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA ales 6160 Oxon Hill Road Oxon Hill, Maryland 23a, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

Fig. 8 mmu Cll Lung Cahen. State Approximate Interval Between and Death Immediate Cause (Final disease or condition resulting in death) Cancer, Stage month **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo the 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 certificate 1 ☐ Yes XXXNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation within 24 hours after deau.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 🔲 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif 2006 who

DHMH 17 Rev 1/2001

10

State

Registrar

ORIGINAL

#210 Clinton, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kai-Yiu Yeung MD

APR 2 6 2006

31. Date filed (Month, Day, Year)

8926 Woodyard Road

32/Registrar's Signature

			Ple	• •			INK. Ensure	•	3	
			For 1_ State	State of I	•	•	t of Health and	Mental Hyg	liene	13246
			Registrar			eniicate	e of Death		leg. No.	1 4 1 2
	Physici	an	Decedent's Name (First, Mide	•				2. Date of Dea Month	ith Day Year	3. Time of Death
	/Medic		Alyce E. Wi					APRIL	_21200	
	Examin	er	4a. Facility Name (If not institution		er)		Town, or Location of Dea	th	4c. County of Dea	th
			MEMORIAL HOSP				ERLAND		ALLEGANY	
н	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birtho	Months	1 Year If Under 24 Hrs Days Hours Min		Year) 9. Bir	thplace (State or Foreign ountry)
	Director		215-12-2007 Usual Residence of Decedent	Α	84 Yr	,		June 1	3,1921 M	ID
	land ow		10a. State 10b. Count	у	10c. City, Town o	r Location				10d. Inside City Limits
	Mary	ğ	MD Alle	gany	Rawling	ıs				1 ☐ Yes 2 ☐ No
	the notif	rec	10e. Street and Number			10f. Zip	Code		10g. Citizen of What C	ountry?
	3a o		23720 McMu	llen Hwy,	SW	21	557		USA	
	be filed within 72 hours after death with the Maryland hal Hygiene. ed other than "naturel", or Items 23a or 28e-1 ehow event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was Deced	ent of Hispanic Origin? (ify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Am	
9	after or Ite	Ē	1 Never Married 2 Ma	Armed Force	₩No			rto Hican, etc.)		te, etc.
03	ral', c	þ	3 ₹Widowed 4 □ Divorce	od If Yes, Give . Year or Date	A es:	1 ☐ Yes 2	2∟XNo Specify:		Specify: W	hite
5-0036	72 ho	sted	15. Decede	ent's Education est grade completed)	16a. D	ecedent's Usua	I Occupation k done during most of wo	orkina	16b. Kind of Business	/Industry
2121	- 23	p d	Elementary/Secondary (0-12)		or 5+)	e. DO NOT us	e retired)	9		
2	filed will Hygien sther the	Completed	12	4	Sch	1001 T	eacher		Educati	on
nd	d oth	Be	17. Father's Name (First, Middle				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>×</u>	2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, the Me	၉	Howard Wil						Wilkes	
Maryland	s 1 end 2 should f Heelth and Mer Item 27 is marks other traumatic		19a. Informant's Name/Relation		1	energy.	(Street and Number or R		1000	
	end feelit m 27 her t	1	Ronald Wil	is, son	23	720 M	cMullen Hy	y, SW.	Rawlings	MD_21557
0	Jes 1 I of H If Ite	1 3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	a 3 □Removal from Str	ate Cometery,	crematory or ot	her place) Memorial	Δnril		
Baltimore,	permit. Pages 1 end 2 Department of Heelth a Importent: If Item 27 is any Injury or other tra ance.		4 ☐Donation 5 ☑ Other (ment Gare	. шами len Mai	Heliottat Haclottat	24,200€	LaVale	, MD
Salt	Depermit Depermit Import any in		21. Signature of Funeral Service		~	TT C	PROPERTY OF THE PROPERTY OF			
-	<u>0</u> 0 = € 0		John	. Hafer	, Ju.	1302	National	Hwy. La	Vale. MD	21502 Approximate
п			23a. Paky Enter the disease, shock, or heart failure.	fr complications that cau st only one cause on eac	h line.	enter the mode	e of dying, such as cardia	ic or respitatory arr	est,	Approximate Interval Between Onset and Death
	Physician		disease or condition		ROVASCULAR					3 WEEKS
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of)					
	± Xuimici		Sequentially list conditions, if any, leading to immediate	b						
1/	ed sit	ine	cause. Enter Underlying Cause (Disease or injury	do ou euc	as a consequence of)					
•	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c	as a consequence of)					
760,	e be executed sicien and e burial-transit	cai E		330.13 (3.	25 2 55/155 425/155 5/7					
687				d						
	leath certificate ettending phys I for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome	me of pregnancy				23d. Date of de	livon
Box	ath tter or u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	n 2 Fetal death	3 ☐ Ectopic pre			Month Month	Day Year
0	0 00	ysi	1 □ Yes 2 No 9 □ Unknown	9□ Unknow		о <u>ш</u> оо. (оро				
۵.	The law requires that the deside hes been signed by the eage 2 should be detached f	P	Part II. Other significant condit	tions contributing to deat	th but not resulting in the	e underlying ca	ause given in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
sp.	uires la sign	d by						1 🗆 Y	es 2□No 3□P	robably 4 Unknown
Ö	w requir been si should	lete						24a. Was a	n 24h Were a	utopsy findings available
of Vital Records,	The lav	Completed						autop: perfor	med? prior to death?	completion of cause of
e		ပိ	25. Was case referred to medic	nl .				1 Tes	2 No 1 □ Yes	2 □ No
₹	Physician: this certificantal director,	00	examiner?	Hospital: 1 Inp	atient 2 ER/Outp		Other	eath Check only or		
of	Phys r this sral di	. To	27. Manner of Death	28a. Date of I			Bc. Injury at		ence 6 Other (Spe	iciry)
O	th. th. : After : funer	tio	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ling (Month,	Day Year) Inju	ry M	Work? 1 ⊟ Yes 2 ⊟ No			
Division	Attendi	fica	3 ☐ Suicide 6 ☐ Could	mined 286. Place of	Injury - At home, farm	, street, factory,	, office	28f. Location (S	treet and Number or R	ural Route Number,
Ö	affer Dire	Certification:	4 Homicide	building	, etc. (Specify)			City or Tow	n, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier	ing Physician: To the be	est of my knowledge, o	eath occurred a	at the time, date and place	e, and due to the c	ause(s) and manner a	s stated.
	n 24 n 24 ne Fu	Medical	(Check only 2 Medics one)	al Examiner: On the basi and manner	r stated.	or investigation,	in my opinion, death occ	urred at the time, o	late and place, and du	e to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certif	ier /		29c.	. License number	2	9d. Date signed (Mon	th, Day, Year)
	_		•	1/ilmfa	2	Т	36766		APRIL 21	2006
	10		30. Name and address of perso	n who completed cause	of death (Item 23a) (Ty		70/00		ACKILLE,	2006
	U		VIK POONAI,M.I		ON_DRIVE C	UMBERLA	AND, MD 2150	12		
	Sta	te	31. Date filed (Month Day, Yea APR 2 6	7) 200C . Reg	jistrar's Signature	- N -				
	Registr	ar	WLK S P	ZUUD JOHN	w Dr A					

Michael Kenneth Westwood

Please Type or Print in Black Indelible Ink

ricase iy	he of Little ill plack indelible lik
State of Maryland /	Department of Health and Mental Hygier

ichael Kennet		STATE OF IVI 1- For State Registrar		nt of Health and Mental l te of Death		J. No. 2006	1221.
Physici ledical Exam		1 Decedent's Name (First, Middle,Last) Michael	Kenneth	Westwood	2. Date of Death Month April 14, 20	Day Year	3 Time of Death
		4a. Facility Name (if not institution, give street 317 Emily St. Apt. 2		4b. City, Town, or Location of Dea Cumberland		4c. County of Death	
Funeral		5 Social Security Number 6. Sex	7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24H		n(MM/DD/YYYY) 9 Birt Foreig	
Director		219-98-2493 1X M 2	F 23	Yrs Months Days Hours M	o5/28/	1982 Col	untry) Maryland
v any		10a. State 10b. County	10c. City, Town o	r Location			10d Inside City Limits
te Maryland or 28a-f show fied at once.	ctor	MD Allegany 10e. Street and Number		Cumberland 10f. Zip Code	100	g. Citizen of What Cour	1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	309 Harrison	Street	21502		USA	
eath with items 2.	Funeral		med Forces?	13 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		14. Race - Ameri White, etc.	can Indian, Black,
s after de ral", or	by Fu	3 Widowed 4 Divorced If Yes, to pr Date	es.	1 Yes 2 X No specify:			hite
72 hours		15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	est grade completed) 16a. De du liege (1-4 or 5+)	ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use r		16b Kind of Business/li	ndustry
within 72 siene her than "Medical	Completed	12 17. Father's Name (First, Middle, Last)	В	lock Layer	me (First, Middle, M	Construct	ion
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be C	Larry Edv	win Westwoo	od Cynth	ia Mar	ie Ri	tchey
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Manelal Hygiens Themporaries. If item 27 is marked other than "natural", or items 23a or 28a-f she important: If tiem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	To	19a. Informant's Name/Relationship (Type, Pr Larry E. Westwood /		Malling Address (Street and Number of 09 Harrison Street			, Zip Code) 1502
re, N s l and s of Health If item		20a. Method of Disposition 1 X Burial 2 Cremation 3 Rer	20b. Place of	Disposition (Name of cemetery, y or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit Pages I ar Department of Re, Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ary's Cemetery 04 22. Name and Address of Facility A	/20/2006	Cumberlan	d, MD
Ba perm Depa Impo		Kalut C. Ac	lun 1	404 Decatur Stre	et, Cumbe	rland, MD	21502
Physician /Medical		23a Part I Enter the disease, or complication failure. List only one cause on each line.	, ,		or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		the second secon	e pneumonta assoct (or as a consequence of):	ated with cocaine use			Deali
	ıer		(or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to	(or as a consequence of):				
executed n and l - transi		d. X UNPENDED AME	NDED it 0 1732 27 p	erME,g855,5/22/06 TT			
760, icate be executed by physician and the burial - transit	Medical	IF FEMALE: 23c.	If yes, outcome of pregnancy	erne, good, 3/22/00 11		23d. Date of delivery	
688 ertif ding	sician/	23b Was decedent pregnant in the past 12 months?	Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic preg Other (Specify)	nancy	Month D	Day Year
P.O. BOX that the death c ned by the atten detached for us	Phys	Part II. Other significant conditions contrib	Unknown		23e. Did tob	pacco use contribute to	the cause of death?
ires that the signed by	ğ					2 No 3 Prob	-
cords law requi has been	Completed				24a. Was ar autops perform	y prior to c	topsy findings available ompletion of cause of
Vital Rec ysician: The l his certificate b		25. Was case referred to medical		26.Place of Death (Chec	1 ✓ Yes 2		s 2 No
of Vital Records, ng Physician: The law requir Noter this certificate has been someral director, page 2 should it	To Be	examiner? 1 ✓ Yes 2 No	TETOOdt	patient 3 DOA Other Nur		Residence 6 V Other	: Scene
ion of tending Pt eath or: After the funeral		27. Manner of Death 1 XX Natural 5 Pending	a. Date of Injury (Month, Day,Year) 28b. Ti	me of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Division tal or Attendii rs after death at Director: A	Certification:	Suicide Could not be	le. Place of Injury - At home, far	m, street, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Ru	ral Route Number, City
Divi		29a. Certifier 1 Cortifuing Physician To	the best of my knowledge, deat	h occurred at the time, date and place, a	1		od
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death The Funeral Directors: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Medical	one) 2 Medical Examiner: On the and m		vestigation, in my opinion, death occurred		. ,	
	Σ	29b. Signature and title of certifier		29c. License number O.C.M.E.	1	29d. Date signed (Mor April 15, 2006	nth, Day, Year)
		30. Name and address of person who complete	, ,				<u>-</u>
	tate	Ling Li, MD. Assistant Medica 31. Date filed (Month, Day, Year)	Examiner 111 Penn	Street, Baltimore, MD 21201			
Regis	trar	31. Date filed (Month, Day, Year) APR 2 6 2006	Blown A. A	parte			-
DHMH 17 Rev 1/3	2001	7007	ORI	GINAL			

			1 - For State Registrar	State of Marylan		artment of Hertificate of L		-	jiene 2000 6	13248
	Physici /Medio	al	Decedent's Name (First, Middle, Last Mary Alice Baggo 4a. Facility Name (If not institution, give			4b. City, Town, or	Logation of Dog	2. Date of Dea Month april 2	Day Year	3. Time of Death 11:35 a M
	Examin		2448 Frizzellbur 5. Social Security Number 6. S	g Road	ast birthday)	Westmin	ster If Under 24 Hrs	s. 8. Date of Birth	Carrol 9. Bi	thplace (State or Foreign
×	Director		080-16-2881 Usual Residence of Decedent 10a. State 10b. County	□M 2K□F 97	Yrs.	Months Days	Hours Min	March		Canada 10d. Inside City Limits
	r the Maryla r 28e-f ehov	Director	MD Carrol I		stmin			1	log. Citizen of What C	1 ☐ Yes 2 🛣 No
36	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel", or items 23s or 28s-f show event, the Maulcal Essuiter main be notified at	by Funeral D	2448 Frizzelli 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		21158 Was Decedent of His If Yes, specify Cubar 1 Yes 2 1				
21215-003	within 72 hour sne. Ihen "naturel	Completed t	15. Decedent's Er (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give lite.	dent's Usual Occupa kind of work done d DO NOT use retired,	tion		16b. Kind of Busines:	s/Industry
nd 2	be filed Ital Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last) Henry Portou		Cate	ring	18. Mother's Na	nme (First, Middle,		Business
	nd 2 shu ith and 27 is m r treum		19a. Informant's Name/Relationship (1982) Betty Baggott - Daggott				ind Number or F		r, City or Town, State,	
altimore,	it. Page rtment o rtant: If njury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 2). Signature of Funeral Service Licer	Removal from State	cindlery, cros	matory or outer place	'		Paltimor	
	perm Depa Impo any i		23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each time.	n. Do not en	Cremation 299 Freder	Society Sicks Rd.	of Mary	land, Inc. 磲, MD 212	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		uence of):				<u> </u>	lears
	ate be executed thysicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of d.						
O. Box 6	The law requires thet the death certifica lie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 NOV6 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3[Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
rds, P	w requires thet been signed by should be deta	۵	Part II. Other significant conditions of	ontributing to death but not rest	ulting in the u	nderlying cause give	on in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
		Completed						24a. Was a autop perfor 1 \(\text{Yes}	sy prior to	
Division of Vital	Attending Physician: The r death. ector: After this certificate h ector: After this certificate h by the funeral director, page	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 I	ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	4 ☐ Nursing		ne) ence 6 □Other (Sp ow injury occurred	ecify)
É		Certification:	3 Suicide 6 Could not be determined	9 29a Blace of Injury At he	ome, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 29b. Signature and title of pertifier	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	pinion, death occ	curred at the time, o	ause(s) and manner a late and place, and du	e to the cause(s)
•			30. Name and address of person to the state of the state	Completed cause of death (Item	1 23a) (Tvna			1	11 /	006 10 21157
	Sta Registi		31. Date filed (Month, Day, Year)	295 Ston	e/ A	ve St 30	77	Westmi	aster 1	10 21157

			For 1 - State Registrar	State of		l / Depa		Health an f Death		-	enns	13249		
of the second	Physici /Medic Examir	al	1. Decedent's Name (First, Midd Eduaro 4a. Facility Name (If not institution	(John	n B	asi	Ab. City, Town	, or Location of D	A	Date of Death Month	Day, Year	63-30 HM		
	Funeral Director		Bultimore Reput 5. Social Security Number 212-16-8148	6. Sex 7	Age (In yrs. la	CAA st birthday) Yrs.	If Under 1 Yes		Hrs. 8. D	Date of Birth Month, Day, Yes 0/3/1918	N/A 9. B MA	irthplace (State or Foreign Country) RYLAND		
Baltimore, Maryland 21215-0036	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location LUTHERVILLE MD BALTIMORE								10d. Inside			
	with the	Director								10g.	Citizen of What C	Country?		
	iii. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ritment of Health and Mental Hygiene. Itanis if Item 23 to marked other than "natural", or teme 23a or 28a-f show injury or other traumatic event, the Madical Exert mental to multiple at injury or other traumatic event, the Madical Exert mental to multiple at	by Funerai	11. Marital Status 12. Was Decedent Ever in U. Armed Forces? 1XIVes 2 \[\] No If Yes, Give Year or Dates: WWTT					f Hispanic Origin uban, Mexican, P	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE				
		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) OTH CDADE 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) CLERK							ng 16b. Kind of Business/Industry GROCERY STORE				
		ro Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Nam 19. DODEDT I DICTOW CD							e (First, Middle, Maiden Surname) WENREICH				
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES TUDOR/NEPHEW 134 OTHORIDGE ROAD LUTHERVILLE, MD 2103 20a. Method of Disposition 1 Burial 25 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									1093 or Town, State		
Baltii	permit. B Departm Importar any nju		21. Signature of Fungral Service		the contraction of the party of	22	2. Name and Add	tress of Facility	THE	JOHNSON	FUNERAL	HOME, P.A. 1286		
760,	Physician /Medical Examiner the purial-transit transit dical Examiner	orchitis 14 men												
	that the death certific: ned by the attending pl detached for use as t	Physician/Med	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day Year			
	tending Phyeiclan: The law requires leath. tor: After this certificate has been sign the funeral director, page 2 should be	by	Paricular Cancer							23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
		e Completed								24a. Was an autopsy performed 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{No} \)			
		To B	Z	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp. 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No								eecify)		
		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route In City or Town, State)											
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	fedical	(Check only 2 Medica	ing Physician: To the tall Examiner: On the base and manner	pest of my know sis of examination or stated.	ledge, deati on and/or in	h occurred at the vestigation, in m	time, date and p y opinion, death	olace, and o occurred at	due to the cause t the time, date a	(s) and manner and di	as stated. ue to the cause(s)		
)	With To Con	Σ	29b. Signature and title of certification	dryu m	ωθ,		29c. Lice	-/829	P	4	L -26 \approx	nith, Day, Year) -2006		
	3+1		30. Name and address of person	YUMD 3	of death (Item 2	23a) (Type,	Print) AND B	Pud Ba	eltem	ere. N	D 21	1218		
	Sta Regist		31. Date filed (Month, Day, Year	7 2006	eistrar's Signatu	ire	Garte							

BROWN

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

7 2006

			For State Registrar	State of Ma	aryland		rtment tificate			ind M	R	eg. No.	15	13251		
Ī	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer April 18, 2006 8:00 AM													
	/Medic Examin		Ab City Tours or Location of Dea													
			l ginford Place #	204				ltin				Balti	1			
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex □M 2∏F 7. Ag	e (In yrs. Ia:	st birthday) Yrs.	If Under 1 Months		If Under a	Min.	8. Date of Birth (Month, Day, Oct 19,	Year) 1927	Cot	nplace (State or Foreign untry) yland		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Musical Exact it are must be recitified at once.	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits		
		៦		* 0		Baltim	ore							1 ☐ Yes 2 ☑ No		
		Director	MD Baltimore Baltimore 106. Street and Number 10f. Zip Code						1	0g. Citizen of	What Co	untry?				
			l Ginford Place	204			21228					USA				
36		by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	1 ☐ Yes 2 No			Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:					14. Race - American Indian, Black, White, etc. Specify: white			
Maryland 21215-0036	2 hou	ted	15. Decedent's Ed	ducation				dent's Usual Occupation					16b. Kind of Business/Industry			
215	e. en "n	Completed	(Specify only highest gra		College (1-4or 5+)			kind of work done during most of working DO NOT use retired)								
7	filed within Hygiene. other then	S	12	0		nu	rsing		10 14-45-	de Nome	/Final Adidata		thea	re		
and	be fill be fill be fill be defined by the below the belo	Be	17. Father's Name (First, Middle, Last)		7							(First, Middle, Maiden Sumame) h Jemina Clarke Ruley				
2	should be ind Mental marked o umatic eve	안	John Thomas Dail 19a. Informant's Name/Relationship (-		19b. Mailir	a Address	(Street a			al Route Number					
Z	id 2 s ith an 17 is r traur		Joseph Bopp/spous	,, ,							Baltimor					
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 l		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State 20b. Place of Dispo cemetery, crer							20c. Location					
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service-Licer	Wade, Dir	ector	-	ate A		•	3ard 2120	655 W. 1	Baltim	ore	Street		
	Physician		23a. Part1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each li	ine.		er the mode	of dying			or respiratory arr			Approximate Interval Between Onset and Death		
\$	/Medical Examiner uysicien and phe prirat-transit		resulting in death)	Due to (or as a consequence of):												
1,092		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (cr as	Due to (ct as a consequence of).											
		cal Exa	resulting in death) Last	Due to (or as a consequence of):												
687	ifficate g phy as the															
P.O. Box	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	Physiclan/Med						□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year			
		by	Harmonia significant continuous continuous gi o daani out not resulting in the directlying casse given in 1 art.								-	co use contribute to the cause of death? 2 100 3 Probably 4 Unknown				
Sor	v requir been s should	ete	HYPERENSION 1 DEMIA 24a. Was an autopsy								an 24b	24b. Were autopsy findings available				
Il Records,		Completed	au pt 1 Ye							autop: perfor	sy prior to completion of cause of death? 2 ☑ 1 ☐ Yes 2 ☐ No					
Vital	ysicien: Th is certificate director, pag	Be	examiner?								h (Check only or					
of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director, After this certific completely filled in by the funeral director,	ition: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?							5 Residence 6 Other (Specify) d. Describe how injury occurred					
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		edical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)													
	To th Withir To th comp	Me	29b. Signature a to fittle of centiner	2 ()					number	20		29d. Date agn	ed (Mont	h, Day, Year)		
			30. Nam and a 3 755 of person who	PHYSICE Completed cause of TLIKAR	death (Item.	2 3a) (Type.	Print)	0.50	250	-9	1	4/2	2016	6		
		ate	JEFFREY (0 31. Date filed (Month, Day, Year)		M trar's Signati	ure) li).CKE	SUC	Mes.	1514	ころいか	P2217 300		
	Si Regist		APR 2 7 20	106 /	w de	100	A B									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#2, perMD, C854, perMD, c854, 4/27/06 TT

State of Maryland / Department of Health and Mental Hygiene

- For Amend item#31, perDVR, MD, C854, 4/27/06

Certificate of Death

Reg. No. For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Year + 2006 Month Physician ++,_ 4:30 P HARLAND C. BILLINGS, SR. APRIL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 301 McMECHEN BALTIMORE ST. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 389-03-1299 08/17/1912 WΙ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ns 23a or 28a-f show 1 XYes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 301 McMECHEN ST by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. The Medical Exactings 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 Yes 2 No Specify WHITE Specify: 3 ☐ Widowed 4 A Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ACME PAINTER 10TH ith and Mentał Hygie 27 is marked other i r traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be IIN ဥ CHARLES BILLINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a HARLAND BILLINGS, JR./SON 1922 NARBERTH AVE., HADDON HGTS., NJ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Important: I eny injury o once. MORELAND MEM. PK. 04/21/2006 BALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WESLEY CHAVIS, JR. FH 21. Signature of Funeral Service Licenses Wesley 2007 EASTERN AVE., BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 1 No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ToF Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Jones J. Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registrar 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 1:10 PM EDMUND CHANESKI AMRIL 23 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A HOSPITAL HARBOK 8. Date of Birth (Month, Day, Year, Nov 27, 19 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1**X** M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours 82 Yrs 1923 Maryland Director 218-18-5675 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits i Hygiene. other then "neturel", or iteme 23s or 28s-f show vent, the Hedical Examinar must be notified at Yes 2□No N/A Baltimore Maryland Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3524 Seventh Street 21225 USA deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ WW 2 Specify. 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Union Local 12 Heavy Equipment Operator permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy, important: if item 27 is marked other eny injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Chaneski Shaum Zygmund Ada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Dennis E Chaneski, 712 East Maple Rd., Linthicum, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4/28/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kevin E 21. Signature of Funeral Service Licensee Mcculty์-Portyntak Funeral Home, P.A. 237 East Patapsco Ave., Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FATURE 20 HOURS /Medical Due to (or as a consequence of) Examiner 4 MONTHS ARCINOMA LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and d-transit The law requires that the death certificate be executed physicien ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical USB as ettending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð RADITATION ESOPHAGITUS 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen (24b. Were autopsy findings available prior to completion of cause of death? CORONARY 24a. Was an ARTERY hes page 2 autopsy this certificate 1 ☐ Yes 20 No 200 No 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending 1 Matural investigation 1 Yes 2 No 2 Accident Ped! i Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 943 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 alnita, M.D. RES 000 APRIL 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RACHANA M. PALNIETKAR HARROR 300LSOUTH HANOVER STREET BALTIMORE MD2/12,7 HOSPITAL 31. Date filed (Month, Pay, Year) State 2006 Registrar

		1 - State Registrar	State of Maryland / Dep <i>Ce</i>	artment of Health and rtificate of Death	Reg. No.	106 13254
	dical	Dorsey H. Cr A. Facility Name (If not institution, give str	aig	4b. City, Town, or Location of Deat	<u> </u>	2006 3. Time of Death 11:25 p M
	niner	Greater Baltimore 5. Social Security Number 6. Sex		Towson	Ba1	timore 9 Birthplace (State or Foreign
Funer Directo		The state of the s	M 2□ F 92 Yrs.	Months Days Hours Min.	April 09, 19	9. Birthplace (State or Foreign Country) Oklahoma
the Marylan 28a-f ahow	Director	10a. State 10b. County Maryland Baltimore 10e. Street and Number	10c. City, Town or L		10g Citizan	10d. Inside City Limits 1 ☐ Yes 2 No of What Country?
3 with		2022 Pleasant Vil	la Avenue	21228		States of America
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examinar must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of	1 A Yes 2 No If Yes, Give Year or Dates: WWII tion 16a. Dece	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2X No Specify: Ident's Usual Occupation Is kind of work done during most of work	Sp 16b. Kind	Race - American Indian, Black, White, etc. ecify: White of Business/Industry
Mithin ne hen "	H Dig	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		-
d 2 Hilled v Hygie thert	ို		0 Busin	ness Owner	Whole	
/lan	To Be				Ridenour	mame)
IOCE, Maryland ges 1 and 2 should be file to Health and Mental Hy if item 27 is marked oth or other traumatic event		19a. Informant's Name/Relationship (Types Richard D. Craig 20a. Method of Disposition 1 Xeurial 2 Cremation 3 Rer	(Son) 2022 20b. Place of Dispresementary, cre	matory or other place)	7e., Catonsvi	L1e. MD. 21228 ion - City or Town, State
Baltimore, permit. Pages 1 ar Depertment of Healtmoortant: If Item any injury or othe	SUCE.	4 Donation 5 Other (Specify) 21. Signal II Duraral Strvice License	2	W Memorial PK 04, 2. Name and Address of Facility LO1 3728 Liberty Road,	ing Byers Fur	ville, Maryland neral Directors,In n, Maryland 21133
Macdical Physician and physician and the burial-transit	dicai Examiner	snock, or near failure. List only one timmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of): Pevel Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardiac NEUMONIA ZU Stahus	or respiratory arrest,	Approximate Interval Between Onset and Death Cay Z days
Geath certifing a strending of for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)	23d	Date of delivery Month Day Year
S, F es tha gned be de	<u>م</u>	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use 1 ☐ Yes 2 ☑N	contribute to the cause of death?
Division of Vital Records, P.O for Attanding Physician: The law requires that the after death. Director: After this certificate hes been signed by the funeral director, pege 2 should be deteched.	e Completed				autopsy performed? 1 ☐ Yes 2 ☑ No	4b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital Physician: rthis certifica	To Be	25. Was case referred o medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpatie	04	th <i>Check</i> only one one 5 ☐ Residence 6 ☐	Other (Secretal
VISION OF Attending Phy r death. ector: After thi by the funeral of		-	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how injury oc	
DIVISION ITEM TEST AND A STREET GREAT SAIL DIVECTOR: SECTION S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and No. City or Town, State)	umber or Rural Route Number,
Tc the Hospitel or within 24 hours afte To the Funeral Direct completely filled in h	Medical	29a. Certifier 1 Certifying Physic	r: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occurrence.	and due to the causo(s) and rred at the time, date and pla	t manner as stated. ce, and due to the cause(s)
To the within To the	Me	29b. Signature and title of certifier		29c. License number	29d. Date si	gned (Month, Day, Year)
		All	Medical Ducto	en 063312	April	23,2006
	State strar	30. Name and address of person who com A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF T	pleted cause of death (Item 23a) (Type,	Print) Chair Not (33 C. 70US	May an Zievy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year William Κ. Deckert LO: YIAM 23 Apri 2000 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore N/AHOSPHO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth March Day Year 1921 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1**™**M 2□F 214-01-8646 85 Yrs Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/ABaltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1814 S. Charles Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No 3 MWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Balto. Gas & Electric Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) C Deckert Elizabeth John Eisenhardt. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Μ. Deckert (Daughter) 3021 Ohio Avenue, Baltimore, Maryland 21227 Deborah 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cem. 04-26-06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully=Polyniak Funeral Home, P.A.
130 E. Fort Avenue, Baltimore, Maryland 21230 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rsotic atherosch iovoscular a Due to (or as a consequence of): fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death Day 4 Pregnant at time of death Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pege Depertment of Important: If any injury or once.

Physician

/Medical

Examiner

Director

Funera

Completed by

Be

۵

Funeral

Director

27 is marked other than "natural", or Itama 23s or 28s-f show traumatic avent, the Mudical Examinar must be notified at

Hygiene.

and Mental

. Peges 1 and 2 should be iment of Health and Ments tant: if tem 27 is marked

illed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760

Ö

α.

Records,

Division of Vital

attending physicien and for use as the burial-transit detached for ۵ cete hes been signed ; page 2 should be det

The law requires that the death certificate be executed Physician/Medical δ Be Completed After this certificate has Hospital or Attending Physician: completely filled in by the funeral director, မှ Certification: death. within 24 hours efter death To the Funeral Director:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

01

24a. Was an autopsy rrited? 22VNo 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 L D to

3 Probably JUnknown

25. Was case referred to medical examiner? 2 No 1 Tes 27. Manner of Death

5 Pending 2 Accident investigation 6 Could not be determined 4 Homicide

1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at М 1 Tes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

3 Suicide

29a. Certifier

Medical

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

		1 - For State Registrar	State of Ma		epartme Certifica			and Me		giene Reg. No		5	325	56
Physic	ian	Decedent's Name (First, Middle, Last) Coomes Dovide							2. Date of De Month	Da		Year	3. Time o	
/Medi Exami		George Davis 4a. Facility Neme (If not institution, give s	street and number)		4b. Cit	y, Town, or	Location of		April	7	2006 . County		12:18	a "
TAGINI.		Southern Maryland	Hospital			Clint	on						eorges	
Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birtl	nday) If Und	er 1 Year	If Under 2 Hours	24 Hrs. :	8. Date of Bir (Month, Da	th		9. Birth	place (State ontry)	or Fo reign
Director		578-28-9632 ^{1&} Usual Residence of Decedent		82	rs.			J	an 28,	192	.4	SC		
yland		10a. State 10b. County		10c. City, Town	or Location		··						10d. Inside C	ity Limits
e Mar	Director	MD Prince (Georges	Cli	nton								1 🗌 Yes	2X No
with th	Dire	10e. Street and Number			10f. 2	ip Code				10g. Ci	tizen of V	Vhat Cou	intry?	
eath v	era	9211 Stuart Lane	12. Was Decedent 8	Ever in U.S.		0735	icpania Orig	nin? /Snac	of Von or No	US		Amor	can Indian,	
(1215-0036 within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show the Modeled Exercities at	Funeral	1 ⊠ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 ☐ N					, Puerto R	ofy Yes or No lican, etc.)	,-		k, White		
ours a	Ď	3 ☐Widowed 4 ☐Divorced	If Yes, Give Year or Dates:	43-46	1 ∐ Yes	2 ⊠ No	Specify:				Specify	blac	k	
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural", or myoriant: other treumatic event, the Medical Executable.	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a.	Decedent's Us Give kind of	vork done d	durina most	of working	g	16b. K	(ind of Bu	siness/li	ndustry	
withir then	E C	Elementary/Secondary (0-12)	College (1-4or 5	·	life. DO NOT	use retired	"			Co	n = +			
Hygin Hygin	Be Co	17. Father's Name (First, Middle, Last)	none	we	lder		18. Mother	r's Name	(First, Middle,		nstrı Sumam		on	
Ilan uld be Aental rked tic ev	To B	Jesse Davis					Marth	ha Hi	11					
and h	-	19a. Informant's Name/Relationship (Type		19b.	Mailing Addre	ss (Street a				er, City	or Town,	State, Zi	p Code)	
and and m 27		Geraldine Palmer/da	aughter	330	8 6th	St. S	E #303	3 Was	hingto	m,	DC 20			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other treumatic event, the Medical Executions and be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R	emoval from State		Disposition (N r, crematory o			Da	ite	2 c. L	ocation -	City or T	own, State	
Itin		4 ☐ Donation 5 ☒ Other (Specify) 21. Signalure of Funeral Service License			22 Name	and Address	ss of Facility							
Bal permi Depa Impo any ir		Ronald S. W	ade, DATE		State	Anat	omy B	Board	655 W	. Ba	1tim	ore	Street	:
		23a. Party. Enter the disease, or complishook, or heart failure. List only or	cations that caused	the death. Do n	t enter the m	more, ode of dyin	g, such as d	cardiac or	respiratory a	rrest,			Approximal Interval Bet	te
Physician		Immediate Cause (Final disease or condition	Agito	Kenny	ztory	Du	ihes	(4)	Snu	ru	ne.		Onset and	Death
/Medical Examiner		resulting in death)	Due to (or as	Leffix a consequence of	f):	1			-/-					
LAUMMER	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as:	rotta	1 (nei	mon	na						
uted I Insit	Examiner	Cause (Disease or injury	Due to (01 23 t	a consequence o	1).									
D, exect an and rial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence o	f):									
58760, icate be executed physicien and s the burial-transit	dicai		l											
C 68 artifica ing ph	Med	IF FEMALE:												
I HECONTGS, P.O. BOX 63 The law requires that the death certific tite has been signed by the attending p age 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Fetal death	3 □Ectopic						23d. Date Mor		,	Year
that the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown	time of death	5 Other (specify)							,	. 04.
IS, P.	y Ph	Part II. Other significant conditions con	tributing to death bu	ut not resulting in	the underlying	cause give	en in Part I.		23e. Did t	obacco	use contr	ibute to	the cause of c	death?
rdS quires n sign		END STAG	E KE	M	9159	CASS	£		1 🗆 '	Yes 2	□No	3 🗆 Pro	babiy 4	nknown
1eCOrd le law requir has been si je 2 should	Completed	DIVERTICULO	SIS						24a. Was		24b. V	Vere aut	opsy findings	available
Of VICAL HE Physician: The la rthis certificate has ral director, page 2	E S								autor perfo	ormed? 2 X No	d	leath?	mpletion of a	ause or
DIVISION Of VITAL HECONDS, I or Attending Physicien: The law requires th after death. Director: After this certificate has been signe I in by the funeral director, page 2 should be	B	25. Was case referred to medical examiner?			-			of Death	(Check only o	1100				
Physi this c	2	1 Yes 2 No		nt 2 ER/Out			4 🗆 1401	· · · · · · · · · · · · · · · · · · ·	e 5 ☐ Resi				fy)	
On ding h. After funer	tion	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day	Year) 28b. Ti	jury M	28c. Injury Work	∕aτ <br Yes 2∐N		3d. Describe	now inju	ry occurr	ed		
VISION Of VITAI Attending Physicien: r death. ector: After this certifica by the funeral director, p	Certification;	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home, far					Bf. Location (Street ar	nd Numbe	er or Rur	al Route Num	nber,
Safte Safte Mi Dire	Cert	4 Homicide	building, etc	: (Specify)					City or To	wn, State	9)			
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying PMs (Check only one) 2 Medical Examin	sician: To the best of per: On the basis of and manner sta	examination and	death occurre /or investigation	ed at the tim on, in my or	ne, date and pinion, deat	d place, ar	nd due to the d at the time,	cause(s date an) and ma d place, a	nner as s and due t	stated. o the cause(s	5)
To th within To th compl	Me	29b. Signature and title of certifier			2	9c. License	number	_		29d. Da	te signed	(Mont)	Day, Year)	
) (bl	M			y's	3885	\$		(4/1	18/0	6	
			mpleted cause of de	eath (Item 23a) (7	Type, Print)	Co	m #	307	Cu	Noi	VN	U)	2073	3/5
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 7 2	32. Registra	ar's Signatura	Spark	8								

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 13257

		Registrar Reg. No.									0 19697	
Physici Medical Exam		Decedent's Name (First, Middle,La	John Jeri	ry Fei	_			2. Date of De Month April 22,	Day	Year	3. Time of Death 1632 hrs	
		4a. Facility Name (if not institution, gi	ve street and number)		41	o. City, Town, or Lo Finksburg	ocation of Dea	ath		County of De arroll	eath	
Funeral Director			7. Age (In yi	rs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours M	Irs. 8. Date of B		For	Birthplace (State or reign Country) Ohio	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygene. 27 is marked other thau "natural", or items 23a or 28a-f show any imatic event, the Medical Examiner must be notified at once.	Funeral Director	Usual Residence of Decedent 10a State Maryland 10b. County Carrol 10e. Street and Number 3160 Cardinal 11. Marital Status 1 Never Married 2 Married	Drive 12. Was Decedent Ever in Armed Forces? 1 Yes 2 X N	n U S.	13. Was	10f. Zip Code 211. Decedent of Hispa s, specify Cuban, N	anic Origin? (Mexican, Puer			White, etc	nerican Indian, Black,	
0036 within 72 hours afte giene. ner thau "natural", Medical Examiner	ompleted by	15. Decedent's Education (Specify of Elementary/Secondary (0-12) 12th	College (1-4 or 5+)		Decedent's luring mos	Yes 2 X No s Usual Occupation st of working life. C r Maker	n (Give kind c 00 NOT use r	etired)	Specify Whit ork done ed) Specify White Specify White Construction Construction			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C		Ferguson				Kat	ne (First, Middle, h1een Sh	nou1t	.s		
MD 2 nd 2 shoul alth and M em 27 is m	2	19a. Informant's Name/Relationship (Kenneth Ferguson 20a. Method of Disposition	n / son	[67	2 Ga	Address (Street a	lace		r, Ma	arylan	d 21015	
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,			Cremation 3 Removal from State Crematory or other place) Other Specify: Other Specify: 1 Service Licensee Crematory or other place) Glen Haven Mem. Park 4/28/2							en Burr	or Town, State	
Balti permit. Departi Importa		23a. Part I. Enter the disease, or com	4001 Ritchie Highway Baltimore								vice, P.A. aryland 21225 Approximate Interval	
/Medical Examiner		failure. List only one cause on e Immediate Cause (Final disease a or condition resulting in death)	Multiple Injuries Due to (or as a consequence	ce of):							Between Onset and Death	
tis sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (24-24-24 right) in death) Last	Due to (or as a consequence									
760, icate be executed physician and the burial - transit	an/Medical E	UNPENDED	·	1,perM	E,g855	5,5/10/06 T	ΙΤ					
68 certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	9 Onknown	f death 5	Othe	I death 3 er (Specify)	Ectopic preg	nancy		Date of deliv	rery Day Year	
0 2 5	ě	Part II. Other significant conditions	contributing to death but n	ot resulting	in the und	derlying cause give	en in Part I.	1 Ye	es 2 🗸	No 3 P	to the cause of death? robably 4 Unknown autopsy findings available	
Division of Vital Records, tal or Attending Physiciau: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should t	Be Completed	25. Was case referred to medical examiner?	performed? 1 ✓ Yes 2 No 1 ✓ Ye Was case referred to medical 26 Place of Death (Check only one)									
f Vi Physi er this	ို	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2		tpatient			sing Home 5		ce 6 🗸 Oth	ner: Scene	
ivision of or Attending Phatter to Director: After to In by the funeral	ation:	1 Natural 5 Pending 2 Accident Investigat		1628		1 Yes	s 2 🗸 No	28d. Describe Driver auto				
Divis	Certification:	3 Suicide 6 Could not determine			m, street,	factory, office buil	Iding, etc.	28f. Location (or Town, 3 Route 140	State)		Rural Route Number, City Md.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	one) 2 Medical Examine	ian: To the best of my know r:On the basis of examination and manner stated									
	Σ	29b Signature and title of certifier				29c. License r O.C.M.					Month, Day, Year)	
164		30. Name and address of person who	completed cause of death (I	tem 23a)		U.C.IVI.	· L ·		April	23, 2006		
124		·	ssistant Medical Exan	,	111 Per	nn Street, Balt	timore, MD	21201				
Si Regis	ate trar	31. Date filed (Month, Day, Year) APR 2. 7. 201	32 Registrar's Sign	nature	Possil	8						
			the second contract of		ALC: NO.	-48"						

ÖRIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year 2006 April 16, Mary Agnes Goodman 6:06 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14 Proctor Avenue Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1□M 2\ F Days Hours 017-16-7130 Director 85 Jan 31, 1921 Massachusetts Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Itams 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD Anne Arundel Glen Burnie filed within 72 hours after death with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 612 Glenview Ave. S.W. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: or than "natural", o 3 ☐ Widowed 4 ☑ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. snt: If item 27 is marked other than try or other traumatic svent, the M Nurse Health Care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Edward Decoteau Mary Ellen Jordan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan M. Crawford/daughter 6801 Rapid Water Way Unit #202 Glen Burnie, MD 21060 loce of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or once. * 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Ronald. Baltimore, MD 21201

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final 4 hceo **Physician** eur disease or condition resulting in death) /Medical buy to (or as a consequence of) **Examiner** 1 stul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ber 9 Unknown 9 Unknown ed by the ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown pinous Completed been (24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s has autopsy certificate 1 Yes 2 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 6 Demer (Specify) 1 ☐ Yes 2 € No 2 2 ER/Outpatient 3 DOA 5 Residence lui After this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending 1 Natural Injury after death.
Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide hours after within 24 hours a 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only the 29b. Signature and tyle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mudisan 10017 trorbat

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2006 1:27 PM M 13, Daniel P. Garrison April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1689 Barrister Court Anne Arundel Crofton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F June 29, Director 139-01-5205 93 1912 New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercities must be notified at 1 Yes 2 No Directo Crofton MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1689 Barrister Court 21114 USA Funeral deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after I ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specity: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 is marked other than other traumatic avent, Item. 10 0 mechanic aircraft 17. Father's Name /First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Daniel Peter Garrison Sr Isabella Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rtment of Health a rtant: If item 27 is Paul R. Frey/son 1689 Barrister Court Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Important: If eny injury o once. * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Riveral Service Sicensee de, Director permit. State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ronchitis **Physician** 48hr /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consectivence of Examiner any, leading to introduc cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician ar P.O. Box 68760, Physician/Medical he use as i attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) the 9 Dunknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, es true 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours after To the Funeral Dire Fo the Hospital 1 Caritying Physician: To the beet of my knowledge, death occurred at the time, data and place, and due to the dauss(s) and manner as statud.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 69 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Su 62 bulls MD 21054 Peter 438 Defen Swite 201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 Month **Physician** April 15, 4:00 AM M Harry D. Gruel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 2047 Hunting Ridge Drive Owings Mills Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 83 Director 183-18-5346 Dec 19, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2√ No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2047 Hunting Ridge Drive 21117 Funeral filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black. White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 143-46 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit, Pages t and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na eny injury or other treumatic event, the Medic 2002. unk Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Gruel Mary Elizabeth Measly

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Gruel/spouse 2047 Hunting Ridge Drive Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Metastatia Cancer /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ UHF Kyowh 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 Sesidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospitel within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 015552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23a) (Type, Print)
23 Crossinuado Dr. Sta#346 Owings Mills Ad Howard aiont 2 M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

A Factory Name of not resimilation gives shead and number? Univ. of Maryland Medical Center Baltimore N/A Feb. 4, 1928 Feb. 4, 1928 Feb. 7, 4, 1928 Feb. 7, 4, 1928 Feb. 7, 1928 Feb.			For State Registrar 1. Decedent's Name (First, Middle,			Department of I Certificate of			Reg. No	IIIII	13261
The Facility Name of an feature gove seems and number? The County of Marry Land Medical Center Baltimore 1. See Seems 1. Seems					GIL	MOUR				y 2006	3. Time of Death 14:15 pt
Social Secury Number Social Secury Number Cape Family Fam		er					or Location of Dea	th		. County of Deat	
211-20-6518 IX MM 2DF 78 vs. Votores Days Hours Mm. Feb. 4, Yeap 28 Pennsy Ivani Too County Too Code T											
10. States 10.0 County 10.0 County 10.0 Colly, from or Location 10.0 Colly 10.0 Coll			211-20-6518		70	Months Dave		B. Date of Bi	rth ay, Year) 1, 19	9. Bird Co Pen	umtru)
23a Part Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Use only one cause on each line. 1	3				10c. City, Tow	n or Location					10d. Inside City Limit
23a Part Enter No dise let of complications that caused the death. On one of one of one of dying, such as cardiac or respiratory arrest, interval Between Cheef and Day Part Cheef and Day Cheef and Day Part Cheef and Day Part Cheef and Day Part Cheef and Day Part Cheef and Day Part Cheef and Day Part Cheef and Day Part Cheef and Day Part Cheef a	offile	ecto		Arundel	F						1 ☐ Yes 2 ☐ N
23a Part Enter the dise te, or complications that caused the death. On too enter the mode of dying, such as cardiac or respiratory arrest, inches the hard process of heart failure. Use on such interval Between the control of the process of the control of the process of the control of	2	吉		Dood)		-		*
232 Fart Enter it dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the control of the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the control of the control	TOTAL STREET	era		12. Was Decedent	Ever in U.S.			Specify Yes or No			
23a Part Effer it dise to or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the part of	Die Ber	Fur	1 ☐ Never Married 2 🛣 Marrie	d 1 M1Vec 2 □ 1	Naraan			rto Rican, etc.)			e, etc.
23.0 Part Chief the dise e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the part of t		d b								Specify:	White
23a / 241. Enter the dise let or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the control of the control	School	lete	(Specify only highest	grade completed)		(Give kind of work done	during most of wo	orking	16b. K	ind of Business	Industry
232 Fart Enter it dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the control of the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the control of the control	N S S S S S S S S S S S S S S S S S S S	omp					,		We	estingho	use
232 Fart Enter it dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the control of the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the control of the control	Vent,				- -,			me (First, Middle			
23a Fart Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the control of the contro	200	10 E					Edith W	illiams			
23a part Enter the dise e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the part of	1										
23.9 Part Cheer five disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the Cheer and Death (Cheer and Deat			1 X Burial 2 ☐ Cremation 3								
23a part Enter the dise e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between the part of					Md. Ve	22 Name and Addr	ose of Eacility				
23a / 7ar1 Littler in dise co o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and obeside the control of the cont	ony				rling	McCully-Po	olyniak F	uneral H	Iome,	P.A.	21122
IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Ves 2 No 3 Probably 3 Unknown 24a. Was an autopsy performed? Ves 2 No 3 Probably 3 Unknown 25. Was case referred to medical examiner? 1 Yes X No 25. Was case referred to medical examiner? 1 Yes X No 25. Was case referred to medical examiner? 1 Yes X No 27. Manner of Death X No 28a. Date of Injury 28b. Time of Injury X No 28b. Time of Injury X No 28b. Time of Injury X No 28b. Time of Injury X No 28b. Time of Injury X No 28b. Time of Injury X No 28b. Place of Injury X No 28b. Time of Injury X No 28b. Place of Injury X No 28b. Time of Injury X No 28b. Place of Injury X No 28b. Time of Injury X No 28b.						not enter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	ar y rano	Approximate Interval Between
24a. Was an autopsy performed? 1 Yes 2 No 25 No 1 Yes 2 No 25 No 2	cal ner		Immedia Cause (F) al disease or comment of the resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lighty that initiated events	a Ische Due to (or as b Coron Due to (or as c.	mic Ca a consequence ary Ar a consequence	rdiomypat of): tery Dise of):	ing, such as cardia ${ m hV}$	c or respiratory a	irrest,		Approximate
24a. Was an autopsy performed? 1 Yes 2 No 25 No 1 Yes 2 No 25 No 2	ner	ā	Immedia Cause (F) al disease or comment of the resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lighty that initiated events	a Ische Due to (or as b Coron Due to (or as c.	mic Ca a consequence ary Ar a consequence	rdiomypat of): tery Dise of):	ing, such as cardia ${ m hV}$	c or respiratory a	rrest,		Approximate Interval Between
25. Was case referred to medical examiner? Yes No	ner ner	ā	Immedian Cause (F) al disease or continent resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Ische Due to (or as b. Coron Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at	mic Ca a consequence ary Ar a consequence a consequence of pregnancy 2 ☐ Fetal death	rdiomypat of): tery Dise of): of):	ing, such as cardia	c or respiratory a	arrest,	23d. Date of del	Approximate Interval Between Onset and Death
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)	be detached for use as the burial-transit	by Physician/Medicai	Immedia Cause (F) al disease or continued in resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths? 1 Yes 2 No 9 Unknown	aIsche Due to (or as bDue to (or as c Due to (or as d	mic Ca a consequence ary Ar a consequence a consequence of pregnancy 2 Fetal death	rdiomypat of): tery Dise of): 3 Ectopic pregnant 5 Other (specify)	ing, such as cardia hy ase	ac or respiratory a	tobacco u	23d. Date of del Month use contribute to	Approximate Interval Between Onset and Death ivery Day Year
25. Was case referred to medical examiner: 1 Minpatient 2 ER/Outpatient 3 DoA 26. Place of Death (Check only one) 1 Yes X No 27. Manner of Death Natural 2 Death North, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Work? 28d. Describe how injury occurred Work? 28d. Location (Street and Number or Rural Route Number City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	2 should be detached for use as the burial-transit	by Physician/Medicai	Immedia Cause (F) al disease or continued in resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths? 1 Yes 2 No 9 Unknown	aIsche Due to (or as bDue to (or as c Due to (or as d	mic Ca a consequence ary Ar a consequence a consequence of pregnancy 2 Fetal death	rdiomypat of): tery Dise of): 3 Ectopic pregnant 5 Other (specify)	ing, such as cardia hy ase	23e. Did	tobacco t	23d. Date of del Month use contribute to No 3 Pr	Approximate Interval Between Onset and Death onset and Death ivery Day Year othe cause of death? obably 4X Unknow
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	call are relative to detaction to see as the containing to the con	ompieted by Physician/Medicai	Immedia Cause (F) al disease or continued in resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths? 1 Yes 2 No 9 Unknown	aIsche Due to (or as bDue to (or as c Due to (or as d	mic Ca a consequence ary Ar a consequence a consequence of pregnancy 2 Fetal death	rdiomypat of): tery Dise of): 3 Ectopic pregnant 5 Other (specify)	ing, such as cardia hy ase	23e. Did 1 24a. Was auto	tobacco v Yes 2	23d. Date of dei Month use contribute to	Approximate Interval Between Onset and Death onset and Death ivery Day Year othe cause of death? obably 4X Unknow stopsy findings availate completion of cause of
30. Names and address of person who completed cause of death (Item 23a) (Type, Print)	page 2 should be detached for use as the burral-fransit	e Completed by Physician/Medical	Immedian Cause (F) all disease or continuation resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	a. Ische Due to (or as b. Coron Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ns contributing to death b	mic Ca a consequence ary Ar a consequence a consequence of pregnancy 2 Fetal death	rdiomypat of): tery Dise of): (a) 3 Dectopic pregnant (b) Other (specify) In the underlying cause given	ing, such as cardia hy ase cy iven in Part I.	23e. Did 1 24a. Was auto perfit 1 Yes auto (Check only in the control of the	tobacco v Yes 2 s an psy ormed? 2 X No	23d. Date of del Month use contribute to No 3 Pr 24b. Were au prior to death? 1 Yes	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? The cause of death? Obably 4X Unknow otopsy findings available completion of cause of X No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	page 2 should be detached for use as the burral-fransit	To Be Completed by Physician/Medical	Immedia Cause (F) al disease or continued in resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Ilijury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes X No	aIsche Due to (or as b	a consequence a consequence a consequence a consequence a consequence consequence a consequence consequence consequence consequence consequence consequence consequence consequence	rdiomypat of): tery Dise of): 3 Ectopic pregnanc 5 Other (specify) In the underlying cause gr	ing, such as cardial hy ase cy Iven in Part I. 26. Place of De	23e. Did 1 □ 24a. Was auto perful 1 □ Yes path (Check only) Home 5 □ Res	tobacco u Yes 2 s an psy pormed? 2 X No one) idence	23d. Date of del Month use contribute to No 3 pri 24b. Were au prior to death? 1 Yes	Approximate Interval Between Onset and Death Onset and Death
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Call ne delacción los as the burial-transit	To Be Completed by Physician/Medical	Immedia Cause (F) all disease or continued resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Ische Due to (or as b. Coron Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ns contributing to death b Hospital: 1 Manpatie 28a. Date of Inju (Month, Da)	mic Ca a consequence ary Ar a consequence a consequence a consequence conseque	rdiomypat of): tery Dise of): 3 Ectopic pregnant 5 Other (specify) In the underlying cause give	ing, such as cardial hy ase Ey Iven in Part I. 26. Place of De ther: 4 \(\text{Nursing lary at one} \)	23e. Did 1 □ 24a. Was auto perful 1 □ Yes path (Check only) Home 5 □ Res	tobacco u Yes 2 s an psy pormed? 2 X No one) idence	23d. Date of del Month use contribute to No 3 pri 24b. Were au prior to death? 1 Yes	Approximate Interval Between Onset and Death Onset and Death Death Onset and D
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Call ne delacred for use as the burial-fransit	To Be Completed by Physician/Medical	Immedia Cause (F) al disease or coloritic resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Ilijury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths? 1	a. Ische Due to (or as b. Coron Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ns contributing to death b Hospital: 1 Manpatie 28a. Date of Injunction of the coron of	mic Ca a consequence ary Ar a consequence a consequence a consequence a consequence a consequence consequence a consequence a consequence a consequence a consequence a consequence begin to the consequence consequence a consequence a consequence begin to the consequence a consequence a consequence a consequence a consequence a consequence begin to the consequence a	rdiomypat of): tery Dise of): 3 Ectopic pregnance 5 Other (specify) In the underlying cause granted and the underlying caus	ing, such as cardial hy ase cy iven in Part I. 26. Place of De ther: 4 \(\) Nursing iny at int iny at int iny at 23e. Did 1 □ 24a. Was auto perfs 1 □ Yes 28d. Describe 28f. Location (tobacco u Yes 2 s an psy prmed? 2 X No one) idence how injui	23d. Date of del Month use contribute to No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Sperry occurred	Approximate Interval Between Onset and Death Death Onset and D	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	neral director, page 2 should be detached for use as the burial-transit a Digital director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Immedia Cause (F) all disease or continent resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Billion) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Ische Due to (or as b. Coron Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown as contributing to death b Hospital: 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc. Physicien: To the best examiner: On the basis of	a consequence ary Ar a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence begin a consequence a consequence a consequence a consequence a consequence begin a consequence a consequence a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence begin a consequence begin a consequence a consequence begin a consequ	rdiomypat of): tery Dise of): tery Dise of): a Getopic pregnance b Other (specify) other (specify) attractiont 3 DOA Time of Injury M arm, street, factory, office b, death occurred at the tery of):	time, date and place	23e. Did 1 24a. Was auto perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining performance p	tobacco v Yes 2 San psy Trimed? 2 No one) idence how injur (Street an wn, State	23d. Date of dei Month use contribute to No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Sperry occurred	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death? It the cause of death? Obably 4X Unknow Itopsy findings availab completion of cause of X No Crify)
	ineral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	Immedia Cause (F) all disease or continued resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Billium) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Ische Due to (or as b. Coron Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown as contributing to death b Hospital: 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc. Physicien: To the best examiner: On the basis of	a consequence ary Ar a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence begin a consequence a consequence a consequence a consequence a consequence begin a consequence a consequence a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence a consequence begin a consequence begin a consequence a consequence begin a consequ	rdiomypat of): tery Dise of): 3 Ectopic pregnant 5 Other (specify) n the underlying cause growth of the course of the c	ing, such as cardial hy ase cy iven in Part I. 26. Place of De ther: 4 \(Nursing in Nurs	23e. Did 1 24a. Was auto perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining perfining performance p	tobacco to Yes 2 s an psy ormed? 2 No one) idence how injured (Street and wn, State cause(s), date and	23d. Date of del Month use contribute to No 3 pr 24b. Were au prior to death? 1 yes 6 Other (Speny occurred	Approximate Interval Between Onset and Death ivery Day Year othe cause of death? obably 4X Unknow otopsy findings available completion of cause of X No cify) ural Route Number, on to the cause(s)
Dr. Shahrooz Sean Kelishadi 22 S. Greene St, Baltimore, Md 21201	neral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	Immedia Cause (F) all disease or continuous resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Wijury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Ische Due to (or as b. Coron Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown as contributing to death b Hospital: 1 Manpatie 28a. Date of Inju (Month, Da) ation of be 28e. Place of Inju building, etc. Physicien: To the best examiner: On the basis of and manner sta	mic Ca a consequence ary Ar a consequence a consequence a consequence a consequence a consequence a consequence a consequence a consequence before a consequence a consequence a consequence before a consequence a consequence before a consequence a consequence before a consequence a consequence before a consequence a consequence before a consequence a consequence before a consequence a consequence a consequence before a consequence a consequence before a consequence a consequence a consequence a consequence before a consequence a consequence a consequence before a consequence a consequence a consequence before a consequence a consequence a consequence before a consequence a consequence before a consequence a consequence before a consequence a consequence before a consequence a consequence before a consequence a consequence before a consequ	rdiomypat of): tery Dise of): 3 Ectopic pregnant 5 Other (specify) In the underlying cause growth arm, street, factory, office and/or investigation, in my 29c. Licen P18	ing, such as cardial hy ase cy iven in Part I. 26. Place of De ther: 4 \(Nursing in Nurs	23e. Did 1	tobacco to Yes 2 s an psy promed? 2 No one) idence how injuited. Street and wn, State cause(s) date and 29d. Da	23d. Date of del Month use contribute to No 3 pr 24b. Were au prior to death? 1 Yes 6 Other (Speny occurred) and Number or Rule) and manner as diplace, and due te signed (Mont)	Approximate Interval Between Onset and Death Death Onset and D

		1	For State Registrar	State of Maryland		rtment of H			giene	06	13262
	Dhysiais	_	Decedent's Name (First, Middle, Last)	· C \				2. Date of De. Month	Day	Year	3. Time of Death
	Physicia /Medic	al	4a. Facility Name (If not institution, give	street and number)		4b. City. Town. or	Location of Death	AFRI		unty of Death	Ø1:45 A
3	Examin	er	Saint Joseph	Medical Cen	ter	,,,	Tows	on		Balt	imore
	Funeral		5. Social Security Number 6. Se	X 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthpl Coun	,
_	Director		Usual Residence of Decedent	/	7			12/3/	26	_ W. V	Rginia
	anyland show		10a. State 10b. County		, Town or Loc	A 2				11	0d. Inside City Limits 1 ☐ Yes 2 XNo
	the Mi	recto	10e. Street and Number	nore		10f. Zip Code	1/2		10g. Citizen	n of What Coun	itry?
	th with 23a or	al DI	9847 Harford	Road		213	134			USA	
	er deal	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No	S. 13. V	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
920	filed within 72 hours after death with the Maryland Hygiene other than "natural", or Iteme 23a or 28a-f show ont, the Medical Examiner must be notified at	ĝ.	1 ☐ Never Married 2 █ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	Yes 20 No	Specify:		Sp	pecify: Wh	ite.
2	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired	during most of work	king	16b. Kind	of Business/Inc	dustry Corp
121	iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Eng	ineer	,		Elec	tronic	Module
Maryland 21215-003	uges 1 and 2 should be filed within 72 hours after death with the Marylan in of Heelth and Mental Hyglene. If item 27 is marked other than "natural, or iteme 23a or 28a-f show or other traumatic event, In Mardical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)	-			18. Mother's Nam	ne (First, Middle	Maiden Su	1	. 1
<u> </u>	hould to d Ment marke matic	ဥ	Jesse Ga 19a, Informant's Name/Relationship (T	STON	19b. Mailin	a Address (Street	and Number or Rui	ral Route Numb	er, City or To	own, State, Zip	,
N N	nd 2 salth an 27 is r	1	Rodney M. Gast	on Son	1271	tunters	Run I	errace	Bel	Hir N	W21015
ore,	es 1 a of He of He of item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Cé	ace of Dispos	sition (Name of	ce)	Date		tion - City or To	
Baltimore,	Part and Link		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service License		KWUOO	(encote)	y 4-2 ss of Facility BA	4-06	DAU	DAGE	E MD
B	permit. Departr Import		Kimberly D.	Za Va otros	E	ANS FUN	BRAL CHY	APEL 88	iou H	ARFORI	ORD.
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that caused the death	. Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	'n	Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA							
	Examiner			Due to (or as a consequ SEVERE CH	RONIC	OBSTRU	CTIVE P	ULMONE	RY D	ISEAS	
7	P ==	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):						
<u>_</u>	axecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
8760,	that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	dical	(d							
9	ertifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ncv				23/	d. Date of delive	arv
Box	death certific e ettending p id for use as	Iclan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3]Ectopic pregnancy] Other <i>(specify)</i> _	/		200	Month	Day Year
P.O.	at the	Physician/Med	9 ☐ Unknown Part II. Other significant conditions o	9□ Unknown	ulting in the u	adortring cause du	en in Part I	23a Did	tobacco use	contribute to t	he cause of death?
	s 5 0	P	Part II. Other significant conditions of	onthouting to death out not rest	altarig in the di	Idenying cause giv	or in talti.		Yes 2 1		
COL	aw require as been sig 2 should b	Completed						24a. Was		24b. Were auto	opsy findings available impletion of cause of
E Re		Com							ormed? 2/2 No	death?	2 No
Vita	Phyeician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	it 3 DOA Ott	26. Place of Dea	ith (Check only iome 5 ☐ Res		Other (Speci	fv)
Division of Vital Records,		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe			,,
sior	Attendin death. ctor: Af y the fur	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No	28f Location	Street and I	Number or Rus	al Route Number,
Θ	of or Attendate after death	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)	eet, radory, onice		City or To	wn, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the ti- vestigation, in my o	me, date and place opinion, death occu	, and due to the irred at the time	cause(s) ar date and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	~ · · · · · · · · · · ·		29c. Licens	se number			signed (Month,	
•	1		0. X	Mella M.C			410		APRIL	2517,	2116.
	6+1		30. Name and address of person who			Print)	RIVE TO	WSON, M	IARYLI	AND 21	204
	St Regist	ate	31. Date filed (Month, Day, Year) APR 2 7 20	32 Registrar's Signa			7 - 7 - 50 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		- I - I - I - I - I - I - I - I - I - I		
	ricgis:		MINNILU	OU THE STATE OF TH							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:00 a **Physician** qee Apr 24, 2006 to hn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randalistown Genesis Eldercare-Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** Hours Min. 1 M M 2 □ F Months Days Yrs So. Carolina 86 Feb 2, 1920 Director 248-14-0613 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or itams 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No **Baltimore** Director N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number WITH 21206 U.S.A. 4916 Bowland Avenue death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be titled within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinar 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ð 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Railroad Elementary/Secondary (0-12) College (1-4or 5+) Railroad Personnel 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Jane Gee Willie Gee 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2420 Marbourne Avenue - Apt 2c Baltimore, Maryland 21230 Rueben Patrick Nephew 20c. Location - City or Town, State 20h. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1

■ Burial 2

□ Cremation 3

□ Removal from State 04/28/06 Lansdowne, Maryland 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery 21. Si natur of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final oronan Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner memi Sequentially list conditions, any, loading to imposite cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consumuence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Cap-Due to (or as a consequenc 4) resulting in death) Last Division of Vital Records, P.O. Box 68760, 10 sclerotil Can ovescular discuse Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 XNo 9 ☐ Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Completed by 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 1 🗆 Yes 1 Yes 2 X No Hospital or Attending Physician: after death.

Director: After this certific
I in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Jursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 2 No ို 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 27. Manner of Death Certification: 1 Naturai 2 Accident 5 ☐ Pending 1 Tyes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide n 24 hours af ie Funeral D ietely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

within 2 the

0

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medical

APR 2 7 2006

Ohiokpehai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D30115

HERT'S AVE MO

29d. Date signed (Month, Day, Year)

2516

21215

39/thmore

			For State Registrar	State	of Marylar	•	artment of rtificate or	Health and Death	Mental H	ygien Reg. N		1326	ending.
91	* *	33	1. Decedent's Name (First, Mid	dle, Last)					2. Date of I		ay Year	3. Time of De	
	Physici /Medic		TONIA Y.	GOUGH					04	10		1 60	М
	Examir		4a. Facility Name (If not institut					or Location of Dec		4	c. County of De	ith	
			GOOD SAME	,				TIMORE			- 0		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		Months Day		n. (Month, I			rthplace (State or Fountry)	oreign
*	Director		214-84-6987 Usual Residence of Decedent		38	3			01-22-	1968	Mar	yland	
	land w		10a. State 10b. Coun	ty	10c. Ci	ity, Town or Lo	cation					10d. Inside City I	imits
	Mary	ţo	MD N	Į A	,	Ra1	timore					11∏ Yes 2	□No
	r 28a	irec	10e. Street and Number	<u> </u>			10f. Zip Code			10g. C	itizen of What C	ountry?	
	h with	O E	2206 Pinewood Ave	mue Apt B4			2	1214			USA		
	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-f show the Modical Exemple multipe modified at	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or It	10-	14. Race - Am Black, Wh		
ဖွ	or Ite		1 X Never Married 2 ☐ Ma		2 X No		1 ☐ Yes 2 🕱 N		, 5,		Specific		
21215-0036	ural',	d by	3 Widowed 4 Divorce	ed Year or								Black	
5-("natu	Completed	15. Deced (Specify only high	ent's Education nest grade completed)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of w	vorking	16b.	Kind of Busines	s/Industry	
121	withir ane. then	m d	Elementary/Secondary (0-12 12) College	(1-4or 5+)	iii e.					D-4		
	be filed ital Hygie of other	ပို	17. Father's Name (First, Middl				Sales	Associate 18. Mother's N	ame (First, Midd	le, Maide	Ret. on Sumame)	11.1	
Maryland	d be ental	o Be	Calvin Gough						Lillie	Mc D	onald		
$\overline{\leq}$	2 should be and Ment Is marked	ဥ	19a. Informant's Name/Relatio	nship (Type, Print)		19b. Maili	ng Address (Stre	et and Number or				Zip Code)	
S	od 2 :		Mattie Seabron/ G	randmother		818 E	. 33rd Sta	eet Baltim	ore, MD 2	1218			
<u>ඉ</u>	f Heal	1 1	20a. Method of Disposition			Place of Dispo	sition (Name of matory or other p	lace)	Date	20c.	Location - City o	Town, State	
e E	Page ent o nt: If ry or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		n State		ial Park	04-2	6-06	Rane	dallstown	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show empirity or other traumatic event, Ita Modical Examiner must be notified at once.		21. Signature of Funeral Service	e Licensee	,	2:	2. Name and Add	ress of Facility					
m	Depermine Depermine Permine Pe		Juner	a gon	8	Wy	lie Funera	al Home 638	N. Gilmo	r Str	eet Balto	MD 21217	
			23a. Part1. Enter the disease, shock, or heart lailure. L	or complications that ist only one cause on	caused the dea each line.	th. Do not en	er the mode of d	ying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between	en .
	Physician		Immediate Cause (Final disease or condition	P	ANCRE	ATIT	15					Onset and Dea	III)
	/Medical		resulting in death)	d	o (or as a consec								
	Examiner		Sequentially list conditions,	D	EPSIS								
/-	D #	lner	if any, leading to immediate cause. Enter Underlying		(or as a consec								
,	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	U	(or as a consec		RENAL	DISEAS	E				
8760,	cate be executed physicien and the burial-transit						IS ERV	THEMAT	Telus				
687	phys phys s the	dlcal		d	- (0/110	0070		TPICHTA					
	certif ding use as	//We	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn						23d. Date of de	alivery	
Вох	Jeath atter	clar	in the past 12 months?	4□Preg	birth 2∏ Feta gnant at time of o		JEctopic pregnar Other (specify)	icy			Month	Day Yea	r
P.O.	The law requires that the death certifit ste has been signed by the attending to page 2 should be detached for use as	Completed by Physician/Me	9 ☐ Unknown	9□ Unk	nown								
œ.	res that signed to be det	y P	Part II. Other significant cond	tions contributing to	death but not res	sulting in the u	nderlying cause	given in Part I.	23e. Dio	tobacco	use contribute	to the cause of dear	h?
rds	w require been sig should b	edt	HYPERTENS	ION					_ 10	Yes	2 □ No 3 □ F	robably 4 Munk	nown
၁	aw re as be 2 sho	plet							24a. Wa	as an	24b. Were a	utopsy lindings ava completion of caus	ulable se ol
Ä	The ate his page	mo;							pe	formed?	death?	s 2□ No	
ita	ysician: The law is certificate has b director, page 2 s	Be	25. Was case referred to medi- examiner?					26. Place of D	eath (Check only	(one)		-	
Ž	> = 0	ပ္	1 ☐ Yes 2 ☒ No			ER/Outpatie	II 3L DOA		Home 5 ☐ Re			ecify)	
u	ing P	ii.	27. Manner of Death 1 ⊠Natural 5 □ Pen-	ding (Mo	e of Injury onth, Day Year)	28b. Time o	W	fork?	28d. Describ	e how inj	ury occurred		
Sic	Attending it death.	cat	3 Suicide 6 □ Cou		o of laiunr - At h	nome form of		☐ Yes 2 ☐ No	28f Location	(Street :	and Number or F	Rural Route Number	
Division of Vital Records,	or A after Direction by	Certification:	4 ☐ Homicide dete		ding, etc. (Speci		reet, factory, offic	•		own, Sta			,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	S E	29a. Certifier 11 Certif	ying Physician: To th	ne best of my kn	owledge, deat	h occurred at the	time, date and pla	ce, and due to th	e cause(s) and manner a	s stated.	
	24 h 24 h Fur etely	Medical	(Check only 2 Medic one)	al Examiner: On the	basis of examination	ation and/or in	vestigation, in my	opinion, death oc	curred at the tim	e, date a	nd place, and du	e to the cause(s)	
	To the within 2 To the complet	₩	29b. Signature and title of certi	fier				nse number		29d. D	ate signed (Mor	th, Day, Year)	
			1 Gudm	lun	MD		RES	DENT		00	4-19-2	.006	
-	3		30. Name and address of person	on who completed ca	use of death (Ite	m 23a) (Type,	Print)			-			
_			HAMID SADEGIA	AN, GOOD 9	AMARITAN	V HOSPIT	TAL, 5601	LOCH RAVE	N BLVD.	BALT	IMORE !	L1239	
16.3	Sta		31. Date filed (Month, Day, Yea	ar) 32.	Registrar's Sign	ature	of .						
#	Regist	ar	APR 2 7	2006	for A	1304	a)						

		For Stata Registrar			ent of Health and N ate of Death	-	lag. No. 106	13265
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Las Noida Gist 4a. Facility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location of Death		th Day Year 21, 2006	3. Time of Deat 11: 30 P
Funeral Director		314 N. Grantly Str. 5. Social Security Number 6. Si 215–10–0602 1. Usual Residence of Decedent		ast birthday) If Ur Yrs. Mont	Baltimore Ider 1 Year If Under 24 Hrs. In Days Hours Min.	8. Date of Birth (Month, Day 08-06-191	Year) 9. Birth Cou 4 Sout	nplace (State or Fore untry) h Carolina
28a-f show	Director	10a. State 10b. County MD NA 10e. Street and Number	10c. City		Itimore Zip Code	1	log. Citizen of What Co	10d. Inside City Lin 1X Yes 2 ☐
giene. r than "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at	Funeral	314 N. Grantly Street 11. Marital Status 1 \(\text{Never Married} 2 \subseteq \text{Married} \text{Married} \text{Married} \text{Married} \text{Married} \text{Married} \text{Married} \qu	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give	S. 13. Was De	21224 seedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		USA 14. Race - Amer Black, White	rican Indian,
ne. han "natural', e Medical Exa	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	Year or Dates:	16a. Decedent's t (Give kind of life. DO NO	Isual Occupation work done during most of work T use retired)	ang	16b. Kind of Business/I	
d other	To Be Co	17. Father's Name (First, Middle, Last) Independence Gist			Mary	y Stroud	Revere Cop Maiden Sumame)	
Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (7) Andrey Morton/ Niece 20a. Method of Disposition 1 (X) Burial 2 Cremation 3 Cherrical Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Removal from State LOU	6745 ace of Disposition (metery, crematory don Park Ce	or other place)	timore, MD		Town, State
ysician Medical caminer		23a. Part1. Enter the disease, or compositions shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence to the death one cause on each line. Due to (or as a consequence to the death one cause on each line.				est,	Approximate Interval Betwee Onset and Deal
physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.		ny Arteny obse	2		
ittending phy for use as the	cal	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	ence of): ncy death 3⊟Ectopi	c pregnancy		23d. Date of deli	-
is been signed by the attending phy 2 should be detached for use as the	by Physiclan/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequent of the consequent	ence of): ncy death 3 □Ectopi ath 5 □ Other	c pregnancy (specify) ig cause given in Part I.	23e, Did tot 1	Month bacco use contribute to es 2 \(\sum \) No 3 \(\sum \) Pro an 24b. Were aut	the cause of deat
this certificate has been signed by the attending phy al director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequence). d. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown ontributing to death but not resu	ence of): ncy death 3 Ectopi ath 5 Other Iting in the underlyir	c pregnancy (specify) ig cause given in Part I.	23a. Did tot 1 Yes 24a. Was a sutops perform 1 Yes 2 th (Check only on one 5 Aeside	Month bacco use contribute to es 2 No 3 Pro ro 24b. Were aut ro y prior to c death? 1 Yes	the cause of deat obably 4 donki topsy findings ava completion of caus
this certificate has been signed by the attending phy al director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) 23c. If yes, outcome of pregnant of the pregnant at time of description of the pregnant at time of the	ence of): acy death 3 Sctopi ath 5 Other Iting in the underlyin ER/Outpatient 3 28b. Time of Injury M me, farm, street, fac	c pregnancy (specify) g cause given in Part I. 26. Place of Deal OOA Cther: 4 \(\) Nursing Ho 28c. Injury at Work? 1 \(\) Yes 2 \(\) No	23a, Did tot 1 Ye 24a. Was a autops perforr 1 Yes 2 th (Check only on one 5 Teside 28d. Describe ho	Month bacco use contribute to es 2 No 3 Pro response of Control of the Control of Control of the Control of	the cause of deat obably 4 Tonki topsy findings ava ompletion of caus
is cartilicate has been signed by the attending phy director, page 2 should be detached for use as the	o Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier 1 Certifying Ph	Due to (or as a consequence of pregnar at little birth 2 Fetal 4 Pregnant at time of de 9 Unknown Dontributing to death but not resure of the second of the secon	ence of): ncy death 3 Sctopi ath 5 Other Iting in the underlyir ER/Outpatient 3 28b. Time of Injury M me, farm, street, factivelying the street of the s	c pregnancy (specify) g cause given in Part I. 26. Place of Deal OA Cther: 4 \(\) Nursing Hc 28c. Injury at Work? 1 \(\) Yes 2 \(\) No tory, office	23a. Did tot 1 Ye 24a. Was a autops perform 1 Yes 2. And Check only on one 5 Meside 28d. Describe how the cared at the time, did to the cared at the time	Month bacco use contribute to es 2 No 3 Pro In 24b. Were aut prior to c death? 1 Yes ence 6 Other (Spec ow injury occurred	the cause of death obably 4 down topsy findings avairon pletion of cause 2 No state.

DHMH 17 Rev 1/2001

Nowo

Sol

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Rock Humphries

JOK 110	ипринс		I- For State Registrar	•	tificate of Death	iu ivientai i		g No 2006	1326
	Physicia Il Exami	an/	1. Decedent's Name (First, Middle, Last) Rock Allen Humphries				2. Date of Death Month	Day Year	3. Time of Death 1527 hrs
ieurce	II LXaIII	i iei	4a. Facility Name (if not institution, give street and number) Atlantic General Hospital		4b. City, Town, o Berlin	r Location of Deat	April 23, 20	4c. County of Death Worcester	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 220–94–0862 1X M 2 F	e (In yrs. las	st birthday) If Under 1 Yes 48 Yrs. Months Day			4, 1957 Co	
	any		Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Location				10d. Inside City Limits
	= .	ō	Maryland Worcester		Ocean City				1 Yes 2 X No
	th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 117 Sandy Hill Avenue		10f. Zip Code 218	4 2	10	g. Citizen of What Cou USA	ntry?
	with the ms 23a be notil	eral	11. Marital Status 12. Was Decedent			ispanic Origin? (§		14. Race - Amer	ican Indian, Black,
	Pages and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene than "natural", or items 23a or 28a-f she unt: If items 73 is marked other than "natural", or items 25a no 28a-f she uris. If item 27 is marked other than "natural", or items 20a or 28a-f she not free traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	X No	1 Yes 2 N	o specify:		White, etc. Specify: Wh:	
	2 hours after "natural", I Examiner		15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5		16a. Decedent's Usual Occupa during most of working life			16b Kind of Business/	Industry
036	led within 72 Hygiene other than the Medical	Completed	7		Laborer			Constru	ction
215-0036	should be filed with and Mental Hygiene 7 is marked other th natic event, the Mec	Be Co	17. Father's Name (First, Middle, Last) Richard A. Eckhard				ne (First, Middle, M ha I. De		
21,	es I and 2 should be fill of Health and Mental Fill item 27 is marked her traumatic event,	To E	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Stree				
e, MD	and 2 s lealth a item 27 traum		Orpha I. Eckhard, Mother 20a Method of Disposition		Place of Disposition (Name of ce		Date	20c. Location - City or	
Baltimore,	Pages lent of F		Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	ate	rematory or other place) ro Crematory I		/25/06	Baltimore	
Balti	permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:		21. Signature of Funeral Service Licensee	1	22 Name and Addres Cremation	Society	Of Mary	land Inc. ore, Maryla	1 04000
	ysician		Thomas Gregor Ama 2 23a. Part I Enter the disease, or complications that caused failure. List only one cause on each line.	the death.	Do not enter the mode of dying	rick Koa g, such as cardiac	d Baltim or respiratory arre	ore, Mary La st, shock, or heart	Approximate Interval Between Onset and
	Medi <mark>cal</mark> caminer		Immediate Cause (Final disease a. Acute Coronary						Death
			or condition resulting in death) Due to (or as a consection sequentially list conditions,						
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	iquanes of	Ý				
/	ted 1 ansit	Exar	events resulting in death) Last Due to (or as a conse	quence of)):				
_	icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED						
Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death with a the bours after death or to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	cian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcor 1 Live birth 4 Pregnant at 2 Vestion 1 Vestion 1 Vestion 2 Vestion		2 Fetal death 3	Ectopic pregr	nancy	23d. Date of deliver Month	y Day Year
Ö.	that the de ned by the detached f	Physic	Part II. Other significant conditions contributing to death	n but not re	esulting in the underlying cause	given in Part I	23e. Did tol	bacco use contribute to	the cause of death?
s, P.O.	requires that the been signed by t	ed by						2 No 3 Pro	
Sord	law req has bee	Completed				-	24a. Was a autops perfor	sy prior to	itopsy findings available completion of cause of
Re	certificate rector, page		25. Was case referred to medical		26.Plac	ce of Death (Chec	1 Yes 2	2 No 1 V	es 2 No
Vita	ing Physician: The law After this certificate has uneral director, page 2 sl	To Be	Tes 2 No		ER/Outpatient 3 DOA			Residence 6 Othe	r:
n of	nding Pt th : After ic funeral	ion:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Month, Day, Y	ry ear)		ury at Work? Yes 2 No	28d Describe h	ow injury occurred	
Division of Vital Records,	pital or Attencours after death eral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	jury - At ho	ome, farm, street, factory, office	building, etc	28f. Location (S or Town, St		ural Route Number, City
)	To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examon manner stated						
	E % E 8	₩	29b. Signature and title of certifier			nse number		29d Date signed (Mc	nth, Day, Year)
			30 Name and address of person who completed cause of c	leath (Item		.M.E.		April 24, 2006	
			Carol Allan, MD Assistant Medical Exar		111 Penn Street, Baltin	nore, MD 212	01		
	S	tate	31. Date filed (Month, Day, Year) 7. Registra	r's Signatu	Anasti)				

ÖRIGINAL

			For State Registrar	State of N	Maryland / De <i>C</i>	partment of Fertificate of			ene 006	13268
	Physici /Medic		1. Decedent's Name (First, Middle	Bryant.	- Harris			2. Date of Death Month	Day Yes	3. Time of Death
	Examin		4a. Facility Name (If not institution, Bon Scrove	rs Hosp	1/2/	Ba	Hungo	t	4c. County of D	eath N/A
	Funeral Director		5. Social Security Number 214 - 58 - 9378 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 2 2 5	Age (In yrs. last birthda 55 Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) 9. 8 , 1950	Birthplace (State or Foreign Country) Maryland
	Maryland Ing at	tor	10a. State 10b. County	N/A	10c. City, Town or		Baltimore			10d. Inside City Limits 1 □ ¥es 2 □ No
	h with the	al Director	10e. Street and Number 959 St. Agnes Lane	Э		10f. Zip Code	21207	10	g. Citizen of What	Country? J.S.A.
920	filed within 72 hours after death with the Maryland Hygione. the than "natural", or Reme 23a or 28e-f ehow the than Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceder Armed Forces ed 1 Yes 2 If Yes, Give Year or Dates	□ ₩∘	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ Mo	lispanic Origin? (S an, Mexican, Puerl Specity:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. Black
Maryland 21215-0036	filed within 72 hours Hygiene. ther than "naturel!, ont, ine Medical Exe	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4o	(Gi	cedent's Usual Occup ive kind of work done b. DO NOT use retired	during most of wo	rking	6b. Kind of Busine	ss/Industry estaurant
land 2	o d ia b	To Be Co	17. Father's Name (First, Middle, I	Last) nymant Bryant			18. Mother's Na	me (First, Middle, M	faiden Sumame) ce O. Stewart	
	27 In s		19a. Informant's Name/Relationsh Howard Webster S		19b. Ma	ulling Address (Street 959 St. Agne				a, Zip Code)
Baltimore,	2 0		20a. Method of Disposition 1 □ Surial 2 SCremation 4 □ Donation 5 □ Other (Sp		te cemetery, c	position (Name of rematory or other place) letro Crematory	1	Date 2	20c. Location - City Catons	or Town, State ville, Maryland
Balti	permit. Page Department of Importent: If any Injury or		21. Manual re of Funeral Service I	censee Val	Kep De	22. Name and Addre		neral Service, Baltimore, Mo	P. A. 1 21217	
	The law requires that the death certificate be executed X In the seen signed by the attending physicien and sage 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	line. //	nter the mode of dyin	_		st,	Approximate Interval Between Onset and Death
.O. Box 6	it the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify) _	,	4.0430.0000	23d. Date of Month	delivery Day Year
rds, P.	quires that the signed by talk to the detact	þ	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause giv	en in Part I.			e to the cause of death? Probably 4 □Unknown
		Completed						24a. Was an autopsy perform 1 Yes 2	prior death	autopsy findings available to completion of cause of ? es 2 \(\text{No} \)
Z.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	ttient 2 🗆 ER/Outpat	ient 3 DOA Oth	er	ath <i>(Check only one</i> lome 5 🗆 Resider		Page 14.
Division of	ding After fune	Certification: To	27. Manne Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could redeterming	28a. Date of In (Month, District Designation 28e. Place of I	njury 28b. Time	of 28c. Injur Wor M 1		28d. Describe how	w injury occurred	Rural Route Number,
Ω	To the Hospitet or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		(Check only 2 Medical 8	g Physician: To the bes Examiner: On the basis	of examination and/or					
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	- Com	M MD	29c. Licens	e number 5295 (29	ed. Date signed (Mo	onth, Day, Year)
	2		2000 W,	who completed cause of Balfmill	ore st	- BAL	timo	re mi	D. 21:	223
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 7 2	32. Regis	strar's Signature	Me)	- 1	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended 4/27/06: item# 23b PT per/ID. 0854 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Hall 3:44 PM April 18 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center ÑΑ Johns Hopkins Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Days 220-82-6458 10-23-59 Director 46 Md Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 2 should be filed within 72 hours and Mental Hygiene.
and Mental Hygiene.
Is marked other then "natural; or Itama 23a or 28a-f show
Is marked other then "natural; or Itama 24a or 28a-f show
Ita Madical Examinar must be notified at 10a State Y☐Yes 2 ☐ No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 USA 1513 E. Chase St Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Baltimore City 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Itam 27 is marked oth any jinjury or other traumatic event ang injury or other traumatic event William Essick Gaylord Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 N. Broadway Apt. A 1, Baltimore, Md. James Coleman Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-22-06 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 21202 Baltimore, Md. lady March F.H. East 1101 E. North Ave. Worner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) failure **Physician** Renal YEAV /Medical Due to (or as a consequence of): Examiner Nephrosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown يم Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Dunknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18, 2006 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, Maryland 21224 catif Omar 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

Elease Darlene Johnson

Please Type or Print in Black Indelible Ink

State of

f Maryland / Department of Health and Mental Hygiene	0000 1007	(
Certificate of Death	2006 1327	1

		Registrar			ertificate	ot e	Death			Re	eg. No.	Car Col	UU	1061
Physici Medical Exam			DARLENE S	JOHNSON						Date of Dea Month April 20, 2	th Day	Yea		3 Time of Death 0650 hrs
,		4a. Facility Name (if not instituti 702 Maple Crest Driv		iumber)		4	tb. City, Town, o		of Death			County o		nty
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthda	y)	If Under 1 Ye	ar If Und	er 24Hrs.	8. Date of Bir	th (MM/D	D/YYYY	9. Birt	nplace (State or
Director		216-68-8709	1 M 2 X F		4.0	Yrs.	Months Da	ys Hours	s Min.				Foreign	1
		Usual Residence of Decedent		L	48				1	JUNE_8	195	7		Intry) MARYLAND
any		10a. State 10b. County	-	10c. C	ity, Town or L	ocatio	on							10d Inside City Limits
nd show ce.	Į.	MARYLAND BA	ALTIMORE		RΔ	T.ጥ '	IMORE							1 Yes 2 XNo
Maryland 28a-f show d at once.	ctc	10e. Street and Number					10f. Zip Code			11	0g. Citize	n of Wh	at Coun	trv?
ith the M 23a or 2 notified	Director	702 MAPLECRES	ST DRIVE				212:	2.0						,.
with the s 23a e noti		11. Marital Status		cedent Ever in	U.S. 13	. Was	S Decedent of H		gin? (Snec	ify Yes or No		.S.A		an Indian, Black,
eath item	Funeral	1 Never Married 2 N	Married Armed F	orces?		If Ye	es, specify Cuba	an, Mexican	, Puerto Ri	can, etc.)		White		arrivatari, Diasir,
0036 within 72 hours after death with the Maryland stene. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once		3 Widowed 4 X Di	vorced If Yes, Give Ye				Yes 2 X N	o specify:			S	pecify:	BLAG	CK.
ours a atura atura	d by	15. Decedent's Education (Spe	or Dates: ecify only highest gra	ade completed)			's Usual Occup					nd of Bus		_
136 hin 72 hours a' e. than "natural	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	durir	ng mo	ost of working life	e. DO NOT	use retired	i)				
0036 within 72 iene. ter than '	m d	12th grade	2yrs	5	DAY	CAF	RE				СН	ILD	CARI	Ξ
1 70 W T 0		17. Father's Name (First, Middle						18 Mother	r's Name (F	irst, Middle, N	laiden Si	urname)		
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than ic event, the Medica	Be	BERNARD JOHN				_				WEBST				
D 2 Should and M atic e	7	19a. Informant's Name/Relation					Address (Stre							
MD and 2 she salth and 2 she salth and 2 she sm 27 is		Carla Jones/Da 20a. Method of Disposition	ughter	Laor	14:	29	Holbro	ok St			e, Ma	aryl	and	21202
of He		1 Burial 2 X Crematio	n 3 Removal f		crematory o	sposit or other	tion (Name of ce er place)	emetery,	"	Date	20c. Lo	cation -	City or 1	own, State
imC Page ment tant: or of	١.	4 Donation 5 Other S		1	METRO (CRE	EMATORY		04-27	7-06	BAL'	ТІМО	RE,	MARYLAND
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th		21. Si vature of Funeral Service	e Licensee		f	ZZNI WII	ame and Address LIAM C	s of Facility	COM	MUNTTY	FIINI	ERAT.	HON	ME P Δ
	0 //	Mulma	4		- 4	120)6 W NOF	7A HTS	JENUE					15 T • A •
Physician /Medical		Part I. Enter the disease, o failure. List only one cause	on each line. Bac	caused the dea Sal Gangl	th. Do not en ia Hemo i	ter the	e mode of dying	such as c	ardiac or re with H	spiratory arre	st, shock	k, or hear	rt .	Approximate Interval Between Onset and
xaminer	1	Immediate Cause (Final dis	a <u>and coo</u>	caine use						, per cerr				Death —
=/	11	or condition resulting in death)	,	a consequence	e of):									
	ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence	of):	-							-	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C											
uted id ansit		events resulting in death) Last	Due to (or as a	a consequence	of):									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	an/Medical	X UNPENDED	AMENDED	item#23	a,27,pe	rME.	,g855,5/1	/06 TT						
68760, sertificate be iding physici	/Me	IF FEMALE: 23b. Was decedent pregnant in t	ho —	outcome of pre	egnancy						23d. I	Date of d	lelivery	
certif	ian	past 12 months?	1 Live	oirth nant at time of	2death _		al death 3	Ectopic	c pregnancy	/	М	lonth	Da	y Year
Box e death of the atter	Physici	1 Yes 2 No 9 V Un			5	Oth	er (Specify)				Ų.			
that the death certificated by the attending detached for use as t		Part II. Other significant condi-	tions contributing t	o death but not	resulting in t	he un	nderlying cause	given in Pa	art I.	23e. Did tol	pacco us	e contrib	ute to th	ne cause of death?
ires that the signed by 1	ğ									1 Yes		prom	_	bly 4 V Unknown
ords, aw requir as been s	Completed							-	_	24a. Was a	n I	24b. W	ere auto	ppsy findings available
COT law I has b	d l							-		autops perforr		pri		mpletion of cause of
tal Records cian: The law requi certificate has been ector, page 2 should	Ö,	25.141			_					1 Y Yes 2			✓ Yes	2 No
of Vital Records, g Physician: The law requir ufter this certificate has been s neral director, page 2 should i	Be	25. Was case referred to medica examiner?	Hospital:		7			of Death ((Check only					
Phys	ို	1 Yes 2 No	28a. Date	Inpatient 2	ER/Outpat 28b. Time				Nursing H		Residence			Scene
n of iding Pt. h.: After is funeral	0	1 X Natural 5 Pen	(Month	n, Day,Year)	Zob. Time	Of III		ıry at Work' Yes 2		d. Describe h	ow injury	occurred	1	
IVISIOR or Attend after death Director:	cati		stigation	a of lains At					- 1					
Division pital or Attendin urs after death, eral Director: A	Certification:	. dete	Id not be 28e. Place rmined (Specify)		nome, tarm, s	street	, factory, office I	building, etc	c. 281	f. Location (So or Town, St		Number	or Rura	Route Number, City
ospit hour uners		4 Homicide	(Opcony)						(4)	_			-	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Exa	hysician: To the beaminer: On the basis	of examination	and/or invest	courre igatio	ed at the time, d on, in my opinior	ate and pla n, death occ	ice, and due curred at the	e to the cause e time, date a	e(s) and n nd place	manner a , and due	s starte e to the	d. cause(s)
To COL	Me	29b. Signature and title of certific	and manner s	stated.			29c. Licens							h, Day, Year)
		(Youl)		L P			O.C.	M.E.				20, 200	,	
		30. Name and address of person			m 23a)									
			sistant Medical	,	,	n St	reet, Baltim	ore, MD	21201					
		31. Date filed (Month, Day, Year)		gistrar's Signa	iture	1	100							
Regist	rar	APR 2 7	2005	and the	AF. AS	200	400							

			1 - For State Registrar	State of N	Maryla		artment <i>tificate</i>			ind M		giene Rag. No.	006	132	1
3	Physici	an	1. Decedent's Name (First, Middle	, Last)		- 1				İ	2. Date of Dea	ath Day	Year	3. Time of D	Death
	/Medic	cal	Sheila 4a. Facility Name (If not institution			Johnso					4	18	2006	11:30	0a ^M
1	Examir	ner	1901 Oakhill		ar)		4b. City, Town, or Location of Death Baltimore					4c. County of Dea			
3	Funeral		5. Social Security Number		Age (In yrs.	ge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.					8. Date of Birth 9. E			thplace (State or	Foreign
**	Director		218-28-7210	1□M 2√F	74	Yrs.	Months	Days	Hours	Min.	(Month, Day	·32		Md.	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City	/ Limits
	Mary -f •hc	tor	Md.			Ba	ltimo	re						1 ½ Yes 2	
	h the	Director	10e. Street and Number				10f. Zip (10g. Citize	on of What Co	ountry?	
	23a c	alD	1901 Oakhill A	Avenue				2121	.8			U	ISA		
	tems	Funeral	11. Maritat Status	12. Was Deceder Armed Force			Vas Decede Yes, specif	ent of His fy Cuban	panic Orig	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	14	Race - Ame		
36	rs afte	by Fi	1 Never Married 2 X Marri 3 Widowed 4 Divorced	ed 1 Tes 2 fill Yes Give Year or Date:		1	☐ Yes 2	No.	Specity:			S		Black	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f ehow he Madical Examinar must be neithed at	ted t	15. Decedent	's Education		16a. Deced	ent's Usual	Occupa	tion			16b. Kind	of Business		
215	thin 7.	ple	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4c	or 5+)	(Give	Decedent's Usual Occupation Give kind of work done during most of workil life. DO NOT use retired)				g				
21	ed wil	Completed	llth grade			Home	maker					Ow	n Home		
and	ntal H ed oth	Be	17. Father's Name (First, Middle, I Joseph	•	James				18. Mother Thel		(First, Middle,	Maiden S			
Maryland	should nd Me mark matic	2	19a. Informant's Name/Relationsh		odineb	19h Mailin	a Address /	Stroot			Route Numbe	r City or 1	Johns		
	nd 2 alth ar		James Johnson	Husba	and						ltimore				
ore,	ss 1 ar		20a. Method of Disposition		20b. I	Place of Dispos	sition (Name	B of			ate		tion · City or		
altimore,	Page ment ant: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			Garriso				4-2	5-06	Owi	ngs Mi	lls, Md.	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "netural", or Items 23a or 28a-1 show any injury or other traumatic event, the Mical Examinar must be neitilised at once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101									timor E. N	e, Md. Worth A	21202 lve.	2	
(R)		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													en
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Col	on Ca	ncer								Onset and De 6 Month	
*	/Medical Examiner		resulting in death)	Due to (or a	as a consec	quence of):									
É		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consec	quence of):									
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	6											
0,	e exection and and and and and and and and and an	Exe	resulting in death) Last	Due to (or a	as a consec	quence of):					140				
8760,	ficate be executed physician and s the burial-transit	dical	N	d											
9	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcom	e of pregn:	ancv									
Вох	death atten	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	al death 3 🗌	Ectopic pred Other (spec	gnancy cifv)				230	d. Date of deli Month	very Day Yea	ar
Ö	that the death cer ed by the attendir detached for use	Physician/Me	9 Unknown	9□ Unknown			(9,23	//							
S, D	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant condition	ns contributing to death	but not res	ulting in the un	derlying cau	ısə givər	in Part I.		23e. Did to	bacco use	contribute to	the cause of dea	ith?
Records,	w requir been si should	ted									1 🗆 Y	es 2 💢	No 3∏Pro	obably 4 Unk	known
Sec.	e law has b	Completed									24a. Was a	SV	prior to c	topsy findings ava	artable se of
_											perform 1 Tes	med? 2 X No	death? 1 ☐ Yes	2 🗆 No	
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	*i	IEB/0		Other			Check only on				
o		F-19	27. Magner of Death	28a. Date of In		ER/Outpatient 28b. Time of		c. Injury a Work?	4 14013		e 5 X Reside			rify)	
ion	ath. r: Aft	atio	1 Naturat 5 ☐ Pending 2 ☐ Accident investig		ay rear)	Injury	М		es 2∐No	0					
Division of	27. Magner of Death 1										ral Route Numbe	IF.			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1X Cartifyin 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	of examina	wledge, death ition and/or invi	onnurred at estigation, in	the time n my opir	date and non, death	lana ar occurred	d dua to the ed	ate and pl	d nameras ace, and due	to the cause(s)	
	To the To the Comp.	Ž	29b. Signature and title of certifier	0	L	/	29c. I	License i	number		2	9d. Date s	igned (Month	, Day, Year)	
	/		1 hard	Liter	NO	DV.	D	00	39	27	8	4/	2110	6	
	5		30. Name and address of person w	no completed cause of	death (Iten	h 23a) (Type, F	rint)	1		01	10	11	10	4 4 1 =	. 1
100	Sta	te	31. Date filed (Month, Day, Year)	32. Pauls	trar's Signa	22	5.	Gr	een	5	, 10a	tamo	re IV	D 212	01
	Registra	-0.00	APR 2	7 2006		M A	est s								

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Franklin D. Jones 1- For State
Registrar Amend Item #10c Per FH G850ff02/27/06 ath
1. Decedent's Name (First, Middle,Last) Reg. No. 2. Date of Death Month Day April 15, 2006 3. Time of Death Physician/ Medical Examiner Year 0048 hrs Franklin D. Jones, Jr.

		4a. Facility Name (if not institution, give street and number) 4b 3015 Lorena Avenue	City, Town, or Location of Death Baltimore	4c. County of Death N / A							
Eurorel		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth(MM/DD/YYYY) 9. Birthplace (State or							
Funeral Director		214-92-0444 1\(\time{A}\text{M}\) 2\(\time{F}\) 27 Yrs.	March David Haves Min	Poreign Country) MD							
	t	Usual Residence of Decedent									
w any		10a. State 10b. County 10c. City, Town or Location	gartimore	10d. Inside City Limits 1 Yes 2 No							
daryland 28a-f show any <u>1 at once.</u>	ō		Lexington Stree	, op o							
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
th the 23a o		806 W.Lexington St - Apt 1	21201 Decedent of Hispanic Origin? (Specify	USA / Yes or No- 14. Race - American Indian, Black,							
ath wi tems	neral	Armod Forces?	an, etc.) 14. Race - American Indian, Black, White, etc.								
ter des	Fun		1 Yes 2XX No f Yes, Give Year 1 Yes 2XX No specify: S								
ours af	d by	15 Deceded Februaries (Provide and bishes) 150 Decedents	hest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busin								
572 hc	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired)								
003(within rene.	ompleted	Music	ian	Music INdustry st, Middle, Maiden Surname)							
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", natic event, the Medical Examiner.	ပ	17. Fatilet 3 Haine (Fitts), Middle, Edst,									
212 ald be Menta mark	o Be	Franklin D. Jones, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Jenean Br Address (Street and Number or Rural	OWNING Route Number, City or Town, State, Zip Code)							
nore, MD 2 ages 1 and 2 shou nt of Health and N tt: If item 27 is n other traumatic		Franklin D. Jones, Sr. 3309 1	Round Rd., Balt	imore. Md. 21225							
ore, ML ss 1 and 2 s of Heaith an If item 27 her traum:	- 3	20a. Method of Disposition 20b. Place of Disposition	on (Name of cemetery, Da	ate 20c. Location - City or Town, State							
Pages ent of nt: 11		12525 Bullat 2 Cremation 3 Removal non-State		2006Baltimore, Md.							
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	21 Senature of Funeral Service Licensee 22. Name and Address of Facility Step Brothers Fun										
œ gg ≣ ï		TALARMO N. WALLEY DEBA	ltimore, Md., 1	.300 Eutaw Place 21217							
Physician Medical		23a. Part 1, finter the disease, or complications that caused the death Do not enter the failure List only one cause on each line.	e mode of dying, such as cardiac or res	Between Onset and							
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Death							
		b									
	Je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
executed an and al - transit											
	Physician/Medical	UNPENDED									
. Box 68760, the death certificate be yet the attending physic ched for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2 Fets	al death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year							
K 68 1 certi endin	ciar	past 12 months? 1 Live birth 2 Feta	er (Specify)	Notice Bay							
	hysi	1 Yes 2 No 9 Unknown g Unknown									
.O. E that the d red by the detached		,	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown							
cords, P.C law requires that has been signed is 2 should be deta	pe			24a. Was an 24b. Were autopsy findings available							
ord aw rec as bee 2 shou	plet			autopsy prior to completion of cause of performed?							
tal Reco	Completed by			1 Yes 2 No 1 Yes 2 No							
Division of Vital Records, pital or Attending Physician: The law requirmeral Director: After this certificate has been sittled in by the funeral director, page 2 should t	Be	25. Was case referred to medical examiner?	26.Place of Death (Check only 3 DOA Other Nursing He								
of Vi ing Physi After this uneral dir	은	1 V Yes 2 No Pate of Injury 28b. Time of In	o name name	d. Describe how injury occurred							
on C nding th. r: Aft	ie.	1 Natural 5 Pending FOUND:	1 Yes 2 ✓ No Su	bject shot							
IVISION OF Attenuter death Director:	fical	2 Accident Investigation Apr 15, 2006 0035 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	t, factory, office building, etc. 28f	Location (Street and Number or Rural Route Number, City							
O to the first of											
Hos 24 h Fur tely	Medical (ed at the time, date and place, and due on, in my opinion, death occurred at the	e to the cause(s) and manner as started. e time, date and place, and due to the cause(s)							
To the within ?	₩ Wec	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
		Carol Apiller	O.C.M.E.	April 15, 2006							
		30. Name and address of person who completed cause of death (Item 23a)									
4			treet, Baltimore, MD 21201								
	tate	g 31. Date filed (Month, Day, Year) 32. Registrar's Signature	de								
Regis	uteli	APR 2 7 2006 (Common APR 2 7 2006)									

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink

e, John		Stat	te of Maryland				Mental H	lygiene		000	~ 100°			
		- For State egistrar		Certi	ficate of	Death			Reg. No.	200	0 1321			
Physician		. Decedent's Name (First, Middle,I	_ast)					2. Date of D		V	3. Time of Death			
edical Examine		John A. Le	.e					April 10	2006	Year	19:40			
	4	a. Facility Name (if not institution,)	4	b. City, Town, or L	ocation of Death	n	4c. C	ounty of De	ath			
1		2446 Etting Street				Baltimore			N	I / A				
Funeral	5	Social Security Number 6.	Sex 7. Ag	je (In yrs, last	birthday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of	Birth (MM/DE)/YYYY) 9. I	Birthplace (State or Foreig			
Director	c	51 56 9/1/	XM 2 F		Yrs.	Months Days	Hours Mir	4/26	/1941	941 Country)				
		251-56-2414 Usual Residence of Decedent	- L	00 C	5 Yrs.			1707	1938 So.Carolina					
any		0a. State 10b. County		10c. City, To	own or Location	on					10d. Inside City Limits			
* .		MD M / A		D 1							1XXYes 2 No			
ylanc a-f sh	ַבַּ	MD N/A 0e. Street and Number		Bal	timor	e 10f. Zip Code			10a Citizer	of What Co	number 2			
Mar r 28:	<u> </u>									I OI WINAL CO	Junity ?			
within 72 hours after death with the Maryland gree er than "natural", or items 23a or 28a-f show. Medical Examiner must be notified at once.	ב ב	2446 Etting St			7	21217			Yes					
th wi the	Lallera	Marital Status Never Married 2 Marr	12. Was Decedent Armed Forces	?		Decedent of Hisp es, specify Cuban,			No- 14	Race - Am White, etc	erican Indian, Black,			
r dea or it	2		1 Yes 2	XX _{No}							D 1 l-			
11215-0036 Id be filed within 72 hours after dental Hygiene, marked other than "matural", event, the Medical Examiner.	2		or Dates:	1.		Yes 2 X Mo					Black			
hour natu	D.	15. Decedent's Education (Specif		dı	6a, Decedent uring	's Usual Occupation	on (Give kind of	work done	16b, Kin	d of Busines	s/Industry			
n 72 n 72 ical j	Ĕ	Elementary/Secondary (0-12)	College (1-4 or			vorking life. DO NO	T use retired)			D				
Mithii iene. er th	Completed	12			Maint	enance				_	er King			
Hyg Hyg Hoth		7. Father's Name (First, Middle, La	ast)			1	8.Mother's Name	e (First, Middle	e, Maiden Su	rname)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	D D	Unk					Unk							
hould by is m stice	2 1	9a. Informant's Name/Relationship	(Type, Print)		_	Address (Street			-					
MD nd 2 sh alth and m 27 is		Willie Bush		logi. Bi							ld. 21205			
Baltimore, MD 2's permit. Pages I and 2 should Department of Health and Mu limportant: If item 27 is mainjury or other traumatic es		20a. Method of Disposition 1 XXBurial 2 Cremation	3 Removal from S		nce of Disposi matory or oth	tion (Name of cem er place)	etery,	Date	20c. Loc	cation - City	or Town, State			
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Spec			rison	Forest	4/2	25/200	60wn	ings	Mills,Md			
alti mit. partm ports ury o	3	. Signature of Funeral Service Li	censee	CX	22. N	ame and Address	of Facility Es	step E	roth	ers F	uneral Sv			
E P P W	1	ONLY /	CIRA	d		0 Eutav								
Physician	1	29a. Part I. Enter the disease, or confutications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Int												
/Medical			a Atherosclerotic	Cardiovas	scular Dise	ease					Death			
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		Journal 1910									
		Sequentially list conditions,	b.											
	<u> </u>	if any, leading to immediate	Due to (or as a cons	equence of):										
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated	С.											
asit ed 1	Examiner	events resulting in death) Last	Due to (or as a cons	equence of):										
cecuted and ransit			d. X AMENDED #7&8 Per FH G8544/27/06 JH											
te be ex ysician burial	5	UNPENDED	A AMENDED #78	88 Per	FH G8	544/27/0	5 JH							
76(icate g phy the b	Physician/inedical	F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outco	me of pregna			7e		ery					
D.O. Box 6876 that the death certificat ned by the attending ph detached for use as the	lan	past 12 months?	1 Live birth	t time of deat	_ = _	aldeath 3	Ectopic pregn	ancy	M	onth	Day Year			
Box e death of the atten	S	1 Yes 2 No 9 Unkno			'' 5 Oth	ner (Specify)								
the d	בֿ _ו	Part II. Other significant condition		th but not resi	ulting in the u	nderlying cause gi	ven in Part I.	23e. Dio	tobacco use	e contribute	to the cause of death?			
	2					, ,		1 1	res 2 N	lo 3 P	robably 4 🗸 Unknown			
	Completed							24a. Wa	is an	24h Were	autopsy findings available			
of Vital Records, ng Physician: The law requir ufter this certificate has been s meral director, page 2 should	<u>be</u>							aut	opsy	prior t	o completion of cause of			
Rec The la icate h	E							1 Ye	formed?	death'				
tal Rectian: The certificate ector, page		25. Was case referred to medical				26.Place	of Death (Check	only one)			harrand			
Vital hysician:	e a	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 E	R/Outpatient	3 DOA	Other Nursi	ng Home 5	Residenc	e 6 🗸 Ot	ner: Scene			
ion of Vital trending Physician: leath. tor: After this certif the funeral director,	<u> </u>	27. Manner of Death	28a. Date of Inj (Month, Day,	ury 2	8b. Time of Ir	njury 28c. Injury	at Work?	28d. Describ	e how injury	occurred				
on and in the full of the full	0	1 Natural 5 Pendin		rear)		1 Y	es 2 No							
Division al or Attendi al Director: led in by the fi	Certification:	2 Accident Investig	29a Place of Ir	niury - At hom	e. farm. stree	t, factory, office bu	ildina. etc.	28f. Location	(Street and	Number or I	Rural Route Number, City			
Div	Ē	3 Suicide 6 Could I	not be	,, · · · · · · · · · · · · · · · · ·		.,,,	and and	or Town			talan toda Hamber, ony			
Divis Hospital or A 24 hours after Funeral Direc	ے گ	4 Homicide			d- 41				()					
Division of Norther Hospital or Attending Phywithin 24 hours after death. To the Funeral Director. After to completely filled in by the funeral	. g	(Check only	sician: To the best of n iner:On the basis of exa											
To the within To the comple	_	2 V	and manner stated			1								
	ed .	Ob Owner and the stands	29b. Signature and title of certifier 29c. License number											
	9	29b. Signature and title of certifier									Month, Day, Year)			
	Med	29b. Signature and title of certifier Theorem 1	(76. 2	nus		O.C.N				11, 2006	Month, Day,Year)			
		29b. Signature and title of certifier Theorbus 1 30. Name and address of person w	ho completed cause of	death (Item 2	3a)						Month, Day, Year)			
5		Theorlin &	ho completed cause of				1.E.	21201			Month, Day, Year)			

DHMH 17 Rev 1/2001 OCME 10/2003

			For Amend Item#20 1 - State Registrar	Ob Spere offi	Ve854 no	4/27/ Cei	6 noont	of H	ealth a	ind M		giene		7	275
*	Physicia	an	1. Decedent's Name (First, Middle, La								2. Date of Dea Month	Day			of Death
	/Medio		4a. Facility Name (If not institution, give	e Marie		ō	4b. City,	Town, or	Location o		APR 26,		JO County of Dea	8:2	O_A'''
			Anne Arundel Me						apoli				nne Aru		
	Funeral Director			Sex 7. 1 □ M 2 🛣 F	Age (In yrs. la		y) If Under 1 Year If Under 24 Hrs. B. Date of B. Months Days Hours Min. AUG 1					Sirth Day, Year) 7, 1966 9. Birthplace (State or Fore Country) Delaware			
	e Maryland 3e-f ehow	Director	10a. State 10b. County	Arundel	10c. City	, Town or Lo		Glen	Burn	ie					City Limits es 2 X No
	with th		10e. Street and Number				10f. Zip		10/1			10 g. Citi	zen of What C	ountry?	
036	mit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland screeneds of Heatin and Mental Hygiene. certainst if them 27 is marked other than "natural", or items 23e or 28e-f show injury or other traumatic event, the Madical Examinar mist be notified at a figure or other traumatic event, the Madical Examinar mist be notified.	by Funeral	1909 Norwich Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	XNo		Was Deced f Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecrfy Yes or No- Rican, etc.)	•	USA 14. Race - Am Black, Whi Specify: W		
Maryland 21215-0036	vithin 72 ho ne. han "natur s Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		or 5+)	life. I	kind of wor DO NOT us	k done d e retired)	u <i>ring</i> most				nd of Business	·	
2	filed v Hygie other t		17. Father's Name (First, Middle, Las.	t)		ACCOL	ıntin	/011			(First, Middle,		ome Bui Sumame)	lder	
ryland	2 should be to and Mental I is marked o	Robert T. Poffenberger 19a. Informant's Name (Prirst, Middle, Last) 18. Mother's Name (Prirst, Middle, Maiden Sumane) Faye T. Beavers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State of the Company of th									r Town State	Zip Code)			
	and 2 s ealth an n 27 is ner trau		Jeffrey S. Moore	2			Norw				n Burni				
altimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	☐Removal from Sta	20b. Pl	ace of Dispo tro Cr LO Cr	sition (Name	her place	Inc.		/06		cation - City of		
Balti	permit. Dept rtm Importa any nju		21. Signature of Funeral Service Lice Edward A Gr	egorchik	-4	22	. Name and	d Addres	s of Facility	y Cr	emation d Balti	Soc	ciety o	f MD,	Inc.
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death)	polications that cause on each	sed the death h line.	Do not ent	- 1.	of dying		cardiac o	r respiratory ar	rest,		Approxim Interval E Onset an	letween
760,	ysicien and burial-transit	dical Examiner	S-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for	as a conseque as a conseque as a conseque	ny 0 \$ se se of):	tis							714	
O. Box 6	The law requires that the death certifica tte has been signed by the attending ph bege 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Vo 9 Unknown		Ectopic pre Other (spe						23d. Date of de Month	elivery Day	Year		
ds, P	uires that signed by ld be deta	þ	Part II. Other significant conditions	contributing to deat	h but not resu	ilting in the u	nderlying ca	ause give	n in Part I.		1		se contribute t		V
Records,		Completed	Kidney fu	ilune							24a. Was autop	sy	prior to death?	utopsy finding completion o	s available cause of
/ita	ician: sertifici ector,	Be (25. Was case referred to medical examiner?	Hasaital:				Otho		of Death	Check only o	ne)			
Division of Vital	Attending Physician: In death. Cotor: Alter this certifice by the funeral director, I	tlon: To	1 Yes 2 No 27. Magner of Death 1- Natural 5 Pending 2 Accident investigation			28b. Time of Injury		Bc. Injury Work	4 1401	:	me 5 Resid			ecify)	
Divisi	Hospitel or Attenc 44 hours effer death Funerel Director: tely filled in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	28e. Place of	Injury - At hor, etc. (Specify	me, farm, str					28f. Location (S City or Tow			lural Route N	ımber,
	To the Hospitel or Attending Ph within 24 hours etter death. To the Funerel Director: Alter th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying P	hysician: To the bearing: On the basis	s of examinati	wledge, deatl ion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s)	and manner a place, and du	s stated. e to the cause	9(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier					License	4		,		e signed (Mon		-
)			Vy/ Hell	in l	UD			00	278				-26-	200	<i>P</i>
	3		30. Name and address of person who	erson u	of death (Item	23a) (Type,	April Aces	10	A	nue	epelis	1	de	2/4	0/
*	Sta Registr		31. Date filed (Month, Day, Year) APR 2	7 2006	ariais Signat	A I	drest			6	/				

VOID

CERTIFICATE #

2006-13276

SEE

CERTIFICATE #

2006-17232

6/8/2006dld

		For Stata Ragistrar		State	of Marylan		artment o				giene Reg. No.	06	13277		
Physicia: /Medica	n	1. Decedent's Nam	ie (First, Middle		ames J.	McCla	in			2. Date of De Month Apr: 1	Day	Year 2006	3. Time of Death 5://6 A M		
Examine		4a. Facility Name (· -	umber) Baltimore			vn, or Loca	ation of Death		4c. County of Death N/A				
Funeral Director		5. Social Security N 250-42-	-5316	6. Sex 1 □ XM 2 □ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Y		Inder 24 Hrs. Jurs Min.	8. Date of Bir (Month, Da Aug 8	th ly, Year) B, 1925	9. Birth Cou Sc	place (State or Foreign Intry) D. Carolina		
Marylend		Usual Residence of 10a. State Maryland	10b. County	N/A	10c. City	, Town or Lo	cation	Baltim	nore				10d. Inside City Limits 1 X Yes 2 No		
ath with the Marylen 23a or 28a-f ehow	II Director	10e. Street and Nu 2501 Viole					10f. Zip Co		21215		10g. Citizen	of What Cou			
efter des	by Funeral	11. Marital Status 1 Never Mari		Armed F	^{2 □ No} 19	43	Vas Decedent f Yes, specify	Cuban, Me	ic Origin? (Specifican, Puerto	ecify Yes or No Rican, etc.)	14. F B	lace - Ameri Black, White, cify:			
permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, eny injury or other traumatic event, Ita Healten Eas	Completed	(Spec	15. Deceden cify only highes	t's Education of grade completed	13	16a. Deced	DO NOT use re	one during etired)	most of work	•	16b. Kind of	ndustry			
ld be filed v ental Hygie ked other t ic event, III	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)													
and 2 shou alth and M 27 is mar er traumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tralisa Osorio Granddaughter 3211 Elliott Street Baltimore, Maryland 21224													
Peges 1 ament of He ant: If item jury or oth		20a. Method of Disposition 1													
permit Depart Import eny inj		+ Tue	Ruce	XII	alla	19	Este 1300	p Broth Eutaw	ers Funer Place Ba	ral Service, altimore, M	<u>d 21217 </u>				
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or typert failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):													
executed on and rial-transit	dical Examiner	Sequentially list or if any, leading to ir cause. Enter Undo Cause (Disease or that initiated event resulting in death)	erlying Tinjury S	S c	(or as a consequ					P					
the death certificate I y the attending physiched for use as the t	Physician/Medic												e of delivery th Day Year		
quires that	<u></u>	Part II. Other signi				_	, -	-			obacco use co Yes 2 □ No		the cause of death?		
The law re	Completed		Diabe	tes Mel	l: fas					24a. Was auto pend 1 Yes	an 24 osy ormed? 2 No	b. Were autoprior to codeath?	opsy findings available ompletion of cause of		
Physician: this certific al director,	0 00	25. Was case reference examiner? 1 Yes 2 2 27. Manner of Dear	No	Hospital:		ER/Outpatien 28b. Time of		Other: 4	☐ Nursing Ho	h (Check only ome 5 ☐ Resident Residen	dence 6 □0		(fy)		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificete hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pendin investig 6 Could i determ	g (Mo.	nth, Day Year) ee of Injury - At ho	Injury	М	Injury at Work? 1 Yes	2 □No		Street and Nu		ral Route Number,		
the Hospitalin 24 hours the Funeral pletely filled	edical	29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physician: To the Exeminer: On the and ma	le best of my know basis of examinat nner stated.	vledge, death ion and/or inv	occurred at the restigation, in a	ne time, da my opinion	ite and place, , death occurr	and due to the red at the time,	cause(s) and date and plac	manner as se, and due t	stated. to the cause(s)		
To To To Com	Σ	29b. Signature and	title of certifie	2=3	- M.A.			oense num ∆			29d. Date sig		, Day, Year)		
7		Chad	J. Hens	who completed car	2401 W Registrar's Signal	23a) (Type,	Print) Lere	B=1	timore	MA	7121	5			
State Registra		31. Date filed (Mor	nth, Day, Year)	2006	Hegistrar's Signal	ure	A)								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** APPLIL SYLVESTER MORPISE 7:22 2006 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CIT NOT APPLICABLE UNIVERSITY OF MARKELAND MEDICAL CENTER If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 □ F Days Hours Director 245-66-7865 62 Aug 11, 1943 No. Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event. The Medical Examinational perceitied at 1 Yes 2 No **Baltimore** Director Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 4333 Pimlico Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo _ Specify: Black 3 → Widowed 4 □ Divorced and Mental Hygiene.
Is marked other than "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Furniture Manufacture Upholsterer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nevada Morrisey Elmon Mornsey P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains once. 4008 Fords Lane Baltimore, Maryland 21215 Monique Morrisey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State 05/02/06 Warsaw, No. Carolina 4 ☐ Donation 5 ☐ Other (Specify) Williams Cemetery 21. Signature of fluneral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** As tory collapse piration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MUSC/e -nvasive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed to Kickney Transplant use as the burial-transit -mmunocamprem, sad Due to (or as a consequence of): that initiated events resulting in death) Last 68760, ed by the attending physician detached for use as the burial Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown P.O. 9 Unknown certificate has been signed rector, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No 24a. Was an autopsy performed 1 Yes Hospital or Attending Phyalcian: After this certifical funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 XInpatient 2 ER/Outpatrent 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Crieck unity one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 212019 G 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Greene 22 5+ red 31. Date filed (Month, Day, Year) APR 2 32. gistrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Amend Item#2 per PHY G854 4/27/06 CCC ertificate of Death Reg. No. 2. Date of Death 4-23-2006 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 3.07 PM WILLIAM NAPFEL 1 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MERCY MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Feb. 5, 1927 Birthplace (State or Foreign Country) If Under 1 Year 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Min. 1**∑**M 2□F Months Hours 79 Director Maryland 216-20-6355 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or other traumatic event, It a Medical Exeminer must be nother traumatic. 10a State 10h County 1 XYes 2 □ No Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 East Chase Street Unit 604 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 D∦es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security College (1-4or 5+) Elementary/Secondary (0-12) Deputy Assistant Pureau Director Administration 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanora Sickal Francis Napfel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francis Joseph Napfel-Nephew 3775 Church Road-Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-25-06 Forest Hill, Maryland permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bel-Air
22. Name and Address of Facility
EVANS CHAPEL OF MEMORIES 21. Signature of Funeral Service Licensee 8800 Harford Road-Parkville, Maryland 21234 marge Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HOURS **Physician** SEPS15 /Medical Due to (or as a consequence of): Examiner MEUMONIA SPIRATION Sequent's ly list can fill on if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner CEREBRAL ARTERY attending physician and for use as the burial-transit The law requires that the death certificate be executed KIGHT MIDDLE resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably should should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 🖪 No certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No After this c funeral dire ပ 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; Injury Natural 5 Pending 2 No death. investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Certifying Physician: To the best of my knowledge, usain occurred at the time, date and place and place, and due to the cause(s) and manner stated. (Check only one) Medi To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D0063326 APR 24 2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MERCY MEDICAL CENTER BALTIMORE MO DHOLAKIA. MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** HELMA 2006 /Medical 4b. City, Town, or Location of MIDDLE KIVER

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 9, 1917 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3213 MILLER BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗘 F 88 Yrs. 181-14-0888 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3213 Miller Avenue 21220 filed within 72 hours after death **Completed by Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 end 2 should be fi f Health and Mental H item 27 ie marked ot Oscar F. Smith Mildred Barnes ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Miller Avenue Middle River, Maryland 21220 Michael Lisee, Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/27/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Struke **Physician** day /Medical Due to (or as a consequence of): Examiner Cancer mondo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) ed by the e 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Bladder Cance 1 Yes 2 10 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical this certificate 2 No 1 Yes Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Soon's Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 Yes 2 No After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 29a. Certifier ₩ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D0031295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCHRAUEN BLUD, P.O.B, Ste 208A, BALTO, MO. 21239 WENDY D. KLOESZ, 32. Registrar's Signature 31. Date filed (Month, Pay State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year LOUIS V. PENNA APRIL 22, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3205 NORTHWIND ROAD CARNEY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ½**□M 2□F Director Yrs. 7/19/1928 217-24-9379 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Iteme 23a or 28a-1 shov other traumatic event, the Medical Examinat must be notified at Directo BALTIMORE 1 ☐ Yes 2 ☐ No CARNEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3205 NORTHWIND ROAD 21234 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Martines 2000. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 YEARS SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES PENNA ROSE BRANCIFORTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES A. PENNA/WIFE 3205 NORTHWIND ROAD BALTIMORE, MD 21234 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State GARDENS OF FAITH CEM. 4/27/2006 1

Burial 2 □ Cremation 3 □ Removal from State Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician ENd STAGE DEMENTIA 2 months /Medical Due to (or as a consequence of): Examiner VA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) anding physician and use as the burial-transit Due to or as a consequence of): that initiated events resulting in death) Last 68760. The law requires that the death certificate be Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Cinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 1 No Division of Vital Hospital or Attending Physician: : After this certifical funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check any one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 V No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Many of Death 28b. Time of 28d. Describe how injury occurred 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide TIV Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) nd title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D06030 011 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) B. to Mi) 9 W. Lake 4. Knox Devid 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

0

State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. SR 2. Date of Death Decedent's Name (First, Middle, Last) Month Vear HOWARD **Physician** RICHARO PFISTERER 12:00 P M APRIL 2006 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner IA 8. Date of Birth Mar 28, 1930 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1X M 2□ F Months Hours 76 Director 216-24-0485 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County items 23a or 28a-f show th and Mental Hygiene. ?7 is marked other than "nature!", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notitled at 1 Yes 2 No Baltimore N/A Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1127 Battery Avenue 21230 USA Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Kore 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 .1 Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) City of Baltimore Security Guard 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be fife Department of Heelth and Mental Hy Importent: If Itam 27 is marked oth any Injury or other traumatic event ADE. Be Elnora Turner George Pfisterer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bertha Elizabeth Pfisterer (Wife) 1127 Battery Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of Md cemetery, crematory or other place) 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4/26/06 Crownsville, Maryland Veteran's Cemetery 4 ☐Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Kevin E. Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Hor 130 East Fort Ave., Balto., Home P.A1230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRA-CRANIAL BLEED 06 DAYS **Physician** /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION OSDAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funaral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit. that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELITIS 1 Yes 2 No 3 Probably 4 Unknown YPERTEN SION 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medicai Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■ npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 2000 APRIL, 22, 2006 00 30. Name and Midres of person who impleted cause of death (Item 23a) (Type, Print) HANOVER BALTIMORE MD 21225 FEYSSIA ST 3001 EYOB 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 7 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death The (First, Middle, Last) 2. Date of Death

			1 - State Registrar		C	ertificate	of Death	R	leg. No.	13283
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	uth Day Year	3. Time of Death
_	Physici: /Medic		Anna Lois Taylor	Peterson					24 2006	9:20 P M
	Examin		4a. Facility Name (If not institution, give street			4b. City, To	wn, or Location of Death	1	4c. County of Dea	
			Gilchrist Center			Tow	/son		Baltimo	re
	Funeral		5. Social Security Number 6. Sex		s. last birthda		Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day	y Year) 9. Bir	thplace (State or Foreign
3	Director		213-38-5764 ^{1□ M}	2X 97	Yrs.	Northis	Says Hours Him.	May 20		* '
a	p ,		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or	Location				10d. Inside City Limits
0	aryla ehov	_			ockeys					1 Tes 2 No
d	Ba-f	ctc	MD Baltimore				X			
0	or 2	Director	10e. Street and Number			10f. Zip C	21030		10g. Citizen of What Co	ountry?
	bors after death with the Maryland rail, or freme 28a or 28a-f ehow	by Funeral	9 Flanders Ridge (pecify Yes or No- o Rican, etc.)	USA					
		14. Race - Ame Black, Whit								
36	s aft	Specify: W	hite							
ع و	within 72 hours after ene. then "netural", or Its the Medical Exerting	16b. Kind of Business	/Industry							
300C	in 72	Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	(Gi	cedent's Usual (ve kind of work . DO NOT use	done during most of wor retired)	king		,
5	i vit	E	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Te	acher			Education	n
0 3	filed Hygi other	Maiden Sumame)								
E	id be ental kad c	ell								
24) 2006	s 1 and 2 should be filed within 72 hr f Health and Mental Hygiene. Item 27 is marked other than "nature other traumatic event, its Medical	r, City or Town, State,	Zip Code)							
2	1 end 2 Health a		Thomas M. Peterson	/son	9 1	Flander	s Ridge Ct.	Cocke	vsville Mi	21030
9	Item other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	20b	. Place of Dis	position (Name rematory or other	s Ridge Ct.	Date	20c. Location - City or	Town, State
0 - 6	Page hent c nt: If	Arendtsvill	e, PA							
T =	permit Pages Depariment of I Important: If Its any in ury or o		21. Signature of Funeral Service Licenses	1000	7	22. Name and	Address of Facility			
> a	Depa Impo eny in		Bryan W. Clary	lung		Lemmo	n Funeral I Padonia Rd	Home of	Dulaney V	alley, Inc.
1			23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the de	ath. Do not	enter the mode	of dying, such as cardiac	or respiratory are	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	11	CAVA	in Va	pirrtry.	fall w		Onset and Death
	/Medical		resulting in death	Due to for s a cons		IC VR	Pilla Ing.	12/1000		war
	Examiner		A CONTRACTOR OF THE PARTY OF TH	Acute	2	neuv	nonia			weeps
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):	•				
V	executed n and ial-transit	Examiner	that initiated events c							
_			resulting in death) Last	Due to (or as a cons	equence of):					
09789	certificate be executed rding physicien and use as the burial-transit	Medical	d					·		
	entifica ling pl	Med	IF FEMALE:							
á	eath ce attend for us		23b. Was decedent pregnant in the past 12 months?	If yes, outcome of preg 1□Live birth 2□Fe	etal death	3 □Ectopic preg			23d. Date of de Month	livery Day Year
7	. 0 0 0	Sici	1 Van aktin	4□ Pregnant at time of 9□ Unknown	f death	5 Other (spec	city)		Month	bay
0	. ∓ > o	by Physician	Part II. Other significant conditions contrib	uting td dooth but got s	oculting in the	undorking cou	en even in Part I	23a Did to	bbacco use contribute to	o the cause of death?
V) 4	8 6 8		an certive	Heart	A		so given al Faiti.	1 □ Y	× /	robably 4 Dunknown
ter	* requir been si	Completed	- 2019	1,	1777	2 - 0 -				
+ 8	a law nasb 82st	ם						24a. Was a autop	sy prior to	utopsy findings available completion of cause of
3	: Th	ខ						perfor		s 2□ No
4	ician: The lar certificate has	Be	25. Was case referred to medical examiner?	utal-			Other	ath Check only or		11
4 6	this ral dir	5	1 105 250 NO	1 ☐ Inpatient 2	☐ ER/Outpat 28b. Time		4 🗆 Nursing F		ence 6 X Other (Spe	roity) H DSPIE
	After	P	1 Natural 5 ☐ Pending	(Month, Day Year)	Injur	y M	: Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe II	ow injury occurred	
2	ttend death ctor: /	ca	3 Suicide 6 Could not be	8e. Place of Injury - At	home farm			28f. Location /S	Street and Number or R	ural Route Number
ANNI	i glago	Certification:	4 Homicide determined	building, etc. (Spe	city)	J. 551, 125151 J. 1		City or Tow		,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physicia (Check only 2 Medical Examiner:				the time, date and place			
	the H the F the F	Medical	one)	and manner stated.						
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	10		- 0	License number		29d. Date signed (Mon	•
			1 4/ Anshor	y pure	7,0	9 0	4300		Tprilds	,2006
	in		30. Name and address of person who come	ed cause of death (pe, Print)	Chales	ST R	of Cots in	121221
	10		W.H.16. (24)	6 mil	678	(/ (-, - 1	0,000	

Registrar

APR 2 7 2006

		-	For Amend Item 8 Registrar	State of Maryla per TH, C859,	09/13/06 Certif	ment of Health ar ind icate of Death	d Mental Hygie	ne 0 0 6	13284
F	Physicia		1. Decedent's Name (First, Middle, Last)		R	OGERS	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		ERNESTINE 4a. Facility Name (If not institution, give s			c. City, Town, or Location of [77.7	4c. County of Death	
			NORTH WEST	1+05 P1		CANPACCS:	, ,		MORE
	uneral rector		5. Social Security Number 6. Sex	7. Age (In yr		Under 1 Year If Under 24 onths Days Hours	Hrs. 8. Date of Birth 07/18/19	9. Birth	hplace (State or Foreign untry)
D			Usuel Residence of Decedent	100	City, Town or Locati				10d Incide City Limits
Maryla	f ahoy	ō	10a. State 10b. County		wrnds	1:16			10d. Inside City Limits 1 ☐ Yes 2
d 21215-0036 filed within 72 hours atter deeth with the Maryland Hygiene.	r 28a-	Funeral Director	10e. Street and Number	+		10f. Zip Code	10g.	. Citizen of What Co	untry?
eth wit	238 c	raiD	11 Devlon Con	url		21117	2/0	USA	<i>p</i>
fter de	r ttem draern	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 274No	If Ye	Decedent of Hispanic Origin s, specify Cuban, Mexican, F	Puerto Rican, etc.)	14. Race - Ame Black, White	
0036	LEID, O	þ	3 Widowed 4 Divorced	Year or Dates:		Yes 2 No Specify:		Specify: 6	lack
15-(in 72 h	"nati	ojete	15. Decedent's Educ (Specify only highest grade	completed)	(Give kind	's Usual Occupation d of work done during most o NOT use retired)	f working	b. Kind of Business	lndustry
d 212 filed with Hygiene.	T T	Completed	Elementary/Secondary (0-12)	CA ege (1-4or 5+)	Die	ician		1:4,5	chools
Maryland 21215-0036 at 2 should be filed within 72 hours att the and Mental Hygiene.	ortant: If itam 27 is marked other then "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examinat must be contilled at 8.	8	Flather's Name (First, Middle, Last)	aux of		18 Mother's	Name (First, Middle, Mai	- (0-	lan
arylan should be nd Mental	ls mark aumatic	٩	9a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing A	ddress (Sund and Number of	or Rural Route Number, C		
Te, Mis 1 and 2 Health a	n 27 la ser tra	(nan/Daught	er 11 Dev	Ion Ct., Owi	ngu Nills, n	10 2111	+
Baltimore,	Important: If Itam 2 eny injury or other once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R	emoval from State	Place of Disposition cemetery, cremator	Memorial PK. 4	T. a	c. Location City or	.14
nit. Pa	ortant injury e.		4 □ Donation 5 □ Other (Specify) 21. Signature of Fine all Service Licens			MICHIET OUT K. T		1115 John	108
Balt permit.	eny ir		Vaughn (. K	reene	87	28 Liberty Re	. Randalli	stown, m	D 21133
ш			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.					Approximate Interval Between Onset and Death
	sician edical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		RENAC	DISEASE	,	
Exa	miner		Sequentially list conditions,)					
8	ısıt	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equanca oly.				
60, be executed	n end ial-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):				
8760,	physicien end s the burial-transit	dical		f					
X 61	attending p I for use as I	/Mec	IF FEMALE:	3c. If yes, outcome of preg	nancy			23d. Date of deli	iveo
Box 6	e atten id for u	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death 3 □Ec	topic pregnancy her (specify)		Month	Day Year
Records, P.O.	been signed by the should be detached	Phys	9 ☐ Unknown Part II. Other significant conditions cor		aculting in the unde	shing cours sives in Part I	23a Did tobac	co use contribute to	the cause of death?
	signe Id be d	d by	Part II. Other significant conditions cor	ithouting to death but not i	azarinið in tua anda	nying cause given in Fait i.		2 □ No 3 □ Pr	
S W req	es been 2 shou	olete					24a. Was an	24b. Were au	itopsy findings available
	<u> </u>	Completed					— autopsy performe 1 ☐ Yes 2 ☑	d? death?	completion of cause of
of Vita Physician:	certific rector,	Be	25. Was case referred to medical examiner?	fospital:		Other	Death (Check only one)	4 CO1 12	
of g Phys	After this funeral di	n: To	1 Yes 2 No	28a. Date of Injury (Month, Day Year)		3 DOA Sure 4 Nurs 28c. Injury at Work?	ng Home 5 Residence 28d. Describe how		city)
Vision Attending	or: Aft the fur	catio	1			M 1 Yes 2 No			
2 25	illed in by the	ertification;	4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, street, cify)	factory, office	City or Town, S	et and Number or Ru State)	ural Route Number,
Hospital	fille	O	29a. Certifier 1 Certifying Physics (Check only 2 Medical Examination)	sician: To the best of my k	knowledge, death or	curred at the time, date and tigation, in my opinion, death	place, and due to the caus	se(s) and manner as	s stated.
the Ho	To the Fun completely	Medicai	one) 29b. Signature and title of certifier	and manner stated.	mation and/or inves	29c. License number		and place, and due	
To	1 00		250. Signature and the of certifier	2	1-p.	D 5 77 7 7		PRIL Z	
			30. Name and address of person who co		tem 23a) (Type, Prin	nt)			
	T		LEVNARD RICHAR	PSON 5401	OLD CO	URT RUAD R	AN PALLSTOW,	U MD ZI	133
	Sta Regist		31. Date filed (Month Pey Reg.) 7	2006 32. Hagistrar's Sig	mature				

Amend item#1, pestate of Maryland TDepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. De dent's Name (First, Middle, Last) Raymond Redolf 3. Time of Death **Physician** mond 0.05 M 2006 /Medical 4c. County of Death Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner BURNIE PN 60 1 Year | If Under 24 Hrs. If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days 10 M 20 F Hours Director 62 21,1943 Maryland 220-38-5438 Usual Residence of Decedent iled within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Maryland Pasadena Director Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 757 222nd Street 21122 U.S.A. Items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 **■**If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No White ō Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Department Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental F Sr. Sue Stinston N. Redolf George RAYMOND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ges 1 and 2 si of Health an George N. Redolf Jr.(Brother) 757 222nd Street, Pasadena, Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemeter Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ò Hill Cemetery 04-24-06 Baltimore, Maryland Department of Importent: If eny injury or ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rterio salerotic **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760, attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【 No 24a. Was an autopsy performed 2 100 1 Yes Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ Propertient 3 ☐ DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 Watural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attence within 24 hours after death To the Funerel Director: 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier me completed cause of death (Item 23a) (Type, Print) JONES, mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

31. Date filed (Month, Day, Year)

gistrar's Signature

32.

2006

			1 - For State Registrar	State of Marylar		rtment of H		R	eg. No. UUD	13286				
	Physici /Medic		Decedent's Name (First, Middle, Last) DOLORES	E. ROBI	NSON			A pro(zs ^{ay} zyu	6,50 Am				
	Examir Funeral Director		4a. Facility Name (If not institution, give s: Baltimore Washington 5. Social Security Number 215-18-9099	n Medical Cer	Her last birthday) Yrs.	4b. City, Town, or Color of Color of Under 1 Year Months Days	Bunul If Under 24 Hrs. Hours Min.	8. Date of Birth May 23,	9 Bi	ath Frundel Thiplace (State or Foreign Thipland				
۔ ٽب	aryland ehow	ž	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Art		y, Town or Loc	eation vern				10d. Inside City Limits 1 ☐ Yes 2 🛣 No				
loves (daath with tha Maryland ma 23a or 28a-f ehow	Funeral Director	Maryland Anne Art 10e. Street and Number 8122 Equestrian D		DE	10f. Zip Code	144	1	0g. Citizen of What C	ountry?				
Dolor 5-0036	hours after daal urai', or items :	by	11. Marital Status 1 Never Married 2 Married 3 Married 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Harden Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.				
	within 72 ana. than "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	(Give A	ent's Usual Occupa kind of work done of NOT use retired Educator	ation furing most of work)		16b. Kind of Business Baltimore	City School				
Robinson e, Maryland 2	Should be filed and Mantal Hygis ie marked other aumatic event, it	To Be C	17. Father's Name (First, Middle, Last) Max Buettne				Re	oslyn						
Robinsの、Baltimore, Maryland 2121	is 1 and 2 should of Haalth and Mar item 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Robinson (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Place of Disposition (Name of competing) Competing a Contraction of Competing											
altimo	permit. Pagas Dapartmant of I Important: If its eny injury or o		20a. Method of Disposition 1											
68760,	Physician /Medical Examiner bhysician and bhysician and the prijal-transit the prijal-transit	edical Examiner	23a Part 1. Enter the disease, or complice shock, or heart failure. List only one shock, or heart failure. List only one disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	End Stage C Due to (or as a conseq Congestive Due to (or as a conseq	hvonic uence of): Ueav uence of): y Hyl	: Obstr	nctive Pi	ulmona	y Disease	Approximate Interval Between Onset and Death				
. Box	ath cartiff ittending or usa as	Physician/Me												
ords, P.	w raquires that tha da been signad by tha e should ba datachad f	þ	Part II. Other significant conditions cont		pacco use contribute t	o the cause of death? robably 4 Unknown								
tal Recc	Tha faw ata has b paga 2 s	e Completed	24a. Was an autopsy findings prior to completion of c death? 1											
Division of Vital Records, P.O	ng Phys ftar this inaral dii	atlon; To B	27. Manuar of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 LI Nursing Ho	me 5□Reside	ence 6 Other (Special Control of the	ocify)				
Divis	To the Hospital or Attendi within 24 hours aftar daath. To the Funaral Director: A complately fillad in by tha fu	al Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 29a. Certifier 1 ☐ Certifying Physic	28e. Place of Injury - At he building, etc. (Specifican: To the best of my kno	y) wledge, death	occurred at the tim	e, date and place	City or Town	suse(s) and manner a	hatch 2				
	To the Ho within 24 h To the Ful complately	Medical	one) 2 Medical Examina	er: On the basis of examina and manner stated.	tion and/or inve	estigation, in my op	oinion, death occurr	ed at the time, da	ate and place, and du	e to the cause(s)				
	54		30. Name and address of person who con George E. Will 31. Date filed (Martin Pays Year)	mpleted cause of death (Item	1 D . (Type, P	DY L	rue Ha	n Bur	April 23	21061				
	Sta Registr	ite	31. Date filed (Month Bays) early 200	32 Registrar's Signa	ture	de	7000			A STATE OF THE PARTY OF THE PAR				

		for Stete Registrer		State of	of Marylar		partmei <i>ertifica</i>			Mental Hy	giene Reg. No.	0 U 5		3287
Physic	ian	1. Decedent's Name	(First, Middle, La	st)						2. Date of D		Ye	ar	3. Time of Death
/Med	cal		ccil	R. K	hode	S				Apri1	23,	2000	5	6:20 PM
Exami	ner	4a. Facility Name (If		e street and nu	imber)			Town, or Lo	n	4c. County of Death				
Funeral Director		332 Beac 5. Social Security Nu 219–22–4772	umber 6. S	ex 2M 2□ F	7. Age (In yrs.	iast birthda Yrs.	Months		f Under 24 Hrs Hours Min.	8. Date of 8 (Month, D				ce (State or Foreign y)
pu *		Usual Residence of 10a. State	Decedent 10b, County			ity, Town or	Location			100. 0,				d. Inside City Limits
Maryle faho	ō	Maryland	Anne Ar	mdo1	7.00. 0.	Pasa							100	1 Yes 2 No
r 28a	rect	10e. Street and Num		mider		rasa		p Code			10g. Citi.	zen of Wha	t Country	y?
th with	Funeral Director	332 Beach A	ve.					211	22		,	11.9	S.A.	
r dea	ıner	11. Marital Status		Armed F		J.S. 1	3. Was Dec	dent of Hisp ecify Cuban,	anic Origin? (S Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - A	-	
rs afte	by F	1 ☐ Never Marrie 3 ☑ Widowed	_	1 ☑ Tes If Yes, G Year or I	2 □ No ive Dates:		1 🗆 Yes	2 No	Specify:			Specify:	T 71.	
iled within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or Items 23a or 28a-f show ant, the Medical Examinar must be routified at			15. Decedent's E	ducation		16a. De	cedent's Us	ial Occupation	on	,	16b. Kii	nd of Busine		itestry
ithin 7	Completed	Elementary/Secon	fy only highest grandary (0-12)		1-4or 5+)	life	e. DO NOT	ork done dur ise retired)	ing most of wo	rking				
iled with the the		12 17. Father's Name (First Middle / ast	2		Sta	tionary			- Cinn Middle			High	School_
o la b ≥	o Be	Ceci1	Mo		Ţ	Rhodes		"	Annie	me (First, Middl	e, <i>m</i> aiden Blanch		C	L _11
should ind Men	2	19a. Informant's Na					ailing Addres	s (Street and		ural Route Num				ampbell code)
a, IVI		Robin E. (Carpenter (Daughter	•)	982	Palmer	Street	Rockleds	ge Florid	a 3295	5		
of Head		20a. Method of Disp	osition Cremation 3	Removal from	20b.	Place of Dis cemetery, c	sposition (Na crematory or	me of other place)		Date		cation - City	or Tow	n, State
callings mit. Pages partment of 1 portant: If It y injury or o		4 Donation	5 Other (Special	y)		Glen Ha			ark 4/2	7/06	Gle	n Burni	ie Ma	ryland
permit. Pages Department of Important: If it any injury or o		21. Signature of Fur	LT /	Mine				nd Address y-Polyn Ountain		ral Home, sadena, M	P.A.	d 21122)	
		23a. Part1. Exter the shock, or hear	e disease, or com t failure. List only	plications that one cause on	caused the dea	th. Do not	enter the mo	de of dying,	such as cardia	c or respiratory	arrest,		li A	Approximate nterval Between
Physician		Immediate Cause (disease or condition resulting in death)		a Clr	simo	Obs	Ame	MIK	pul	mona	9 1	h sea	re "	Onset and Death
/Medical Examiner		resulting in death)		Due to	(or as a conse	quence ol):			/					
	Je.	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i	nditions, mediate	b. Due to	(or as a consec	quence of):								
cuted nd ransit	Examiner	that initiated events		c										
icate be executed physicien and s the burial-transit		resulting in death) L	ast	Due to	(or as a consec	quence of):								
oor ou, ificate be executed 3 physicien and as the burial-transit	edicai		•	d								-	-	
certif certif ding		IF FEMALE: 23b. Was decedent	preofant		itcome of pregn						2	3d. Date of	delivery	
death death e atte	Physician/M	in the past 12 to	months?	4□Preg	birth 2 ☐ Fet nant at time of		3 □Ectopic p 5 □ Other (s					Month		ay Year
of the	Phys	9 Unknown		9□ Unkr										
The Cords, F.O. BOX of The law requires thet the death certifate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other signifi	cant conditions	contributing to o	leath but not re	sulting in the	e underlying	cause given	in Part I.		tobacco u			cause of death?
law requires as been sign 2 should be	etec									24a. Wa				
he lay e has	Completed									aut	opsy formed?	prior deat	to comp	bletion of cause of
VICAL Ician: T certificat ector, pa	a	25. Was case referr	ed to medical					2	6. Place of De	1 ☐ Yes ath (Check only		1 🗆	Yes 2	₽No
hysici hysici nis ce	To B	examiner? 1 Tes 2	No	Hospital: 1	Inpatient 2] ER/Outpat	tient 3 🗆 🗅	Othon		lome 5 Res		Other (Specify)	
ing Phy After this		27. Manner of Death 1 Natural	5 Pending		of Injury oth, Day Year)	28b. Time Injur		28c, Injury a Work?		28d. Describe	how injur	y occurred		
rattending rattending er death. ractor: Afte by the fune	licat	2 Accident 3 Suicide	investigatio	e One Dies	e of Injury - At h	ome farm	M street lacto		s 2 □No	28f Location	(Street an	d Number o	r Dural I	Route Number.
el or A	Certification:	4 🗌 Homicide	determined	build	ling, etc. (Speci	fy)	31.001, 12010	y, onloo			own, State,		, , , , , , , , , , , , , , , , , , , ,	TOUTE NUMBER,
To the Hospitel or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical (29a. Certifier (Check only one)	1 Certifying Pt	niner: On the l	e best of my kn pasis of examin oner stated.	owledge, de ation and/or	eath occurre r investigatio	d at the time, n, in my opin	date and place ion, death occi	e, and due to thurred at the time	e cause(s) e, date and	and manne place, and	r as stat	ed. he cause(s)
To the within To the	Me		title of certifier		>		29	c. License n			29d. Dat	e signed (N	fonth, Da	ay, Year)
111/		J. G	ON.	ce o	N				2820		7	4/ 24	1/0	6
HX		30. Name and address	ass of person who	3 .)					in Rd.	0	1		
0 7 7 0	nte.	31. Date filed (Mont	stopher		Sorja Registrars Sign		370	by m	ountai	n Kd.	rasc	oden	2 2	1199
Regis	ate trar	AF	R 2 7 20	06	in a la	E De	eath i							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 8 per Th 8855 5-2-06 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 144 24,200 Ellen Marie Robins /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b.-Gity. Town, or Location of Death Examiner timore Gren HIAL NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 101) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛱 F 232-70-1441 October - 1942 West Virginia **Director** 63 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Maryland Anne Arundel Severn Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1673 Shannon O. Circle 21144 United States Funeral itama 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 1 ☐ Yes 2 No Specify: Specify: white ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 11 own home House wife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lansing Elmer ၉ Jessie Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Truro Lane, Crofton, MD 21114 Lynn Brooks/daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition West Arundel
Crematory May 1, 2006 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, MD 21113 21. Signature of Funeral Service Licensee M01427 omenico modes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ta **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or/as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day 5 Other (specify) 4☐ Pregnant at time of death 9 Unknown 9 Unknown sete has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No this certificate 2 No 1 Yes 1 TYes within 24 hours after death.

To the Funaral Diractor: After this certified completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours af To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

Baltimore,

Box 68760.

Division of Vital Records, P.O.

31. Date filed (Month, Day, Year)

29b. Signature and title of certified

tonio

istrar's Signature

30. Name and address of person who completed cause of death (Item a) (Type, Print) Gorordo

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** avenel 10:25 A HORIL 90 2006 Jeneva /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner BALTIMORE** 607 N. ELLWOOD AVENUE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🐼 F Yrs. 76 Director 248-72-4580 Apr 2, 1930 S.C Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location worle other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **BALTIMORE** Director MD 28a-f 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 607 N. ELLWOOD 21205 or itams 23e Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 TNo Specify: Specify Black þ 3 XWidowed 4 ☐ Divorced naturai Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done du life. DO NOT use retired) during most of working Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SERVICES COOK 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GRACIE PINKEY WILLIE DEAS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 607 N. ELLWOOD BALTIMORE, MD 21205 DAVID DEAS BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □R moval from State permit. Page Department of importent: if any injury or 04/29/06 BALTIMORE, MD 4 Donation 5 Other (Specify) MOUNT ZION CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Lic Miller's Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 Approximate Interval Between Onset and Death or complications that ceused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a Part1. Enter the disease shock, or heart failure. Immediate Cause (Final LUNG CANCER Prysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown DIABETES, CONCESTIVE HEART FAILURE CHRONIC Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FAILURE, HYPERTENSION CORONARY page 2 has performed? Yes 20 No 1 🗌 Yes 1 🗌 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be BROTHER'S Tot Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1-8 Natural 5 Pendina after death.

I Director: Af
d in by the fur 1 Tyes 2 □ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely i 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar Jenniter

Mayashi

31. Date filed (Month, Day, Year) APR 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

2006

062032

5305 HOPKINS BAYVIEW CIRCLE, BALTIMORE, MD 21224

6 James & James Circle BALTIMORE, MD 21224

24

2006

Physician Middles Examiner Final Middles Final M	329(
Foundation Figure 1 Figu	3. Time of Death
202-46-8881 150 M 2 F 51 Vis. Months Days Hours Min. Okenith, Day Year) New Country	ORE (State or Forei
Maryland Raltimore 10.7 2p Code 10.9 Citizen of What County 10.0 Surest and Number of Plant Reliable Number (Plant Frame (First, Middles, Madden Surmanne) 10.0 Surest and Number of Plant Reliable Number (Plant Frame (First, Middles, Madden Surmanne) 10.0 Surest and Number of Plant Reliable Number (Plant Frame (First, Middles, Madden Surmanne) 10.0 Surgeturing Surest and Number of Plant Reliable Number (Plant Frame (First, Middles, Madden Surmanne) 10.0 Surgeturing Surest and Number of Plant Reliable Number (Plant Frame (First, Middles, Madden Surmanne) 10.0 Surgeturing Surest and Number of Plant Reliable Number (Plant Frame (Plant Frame (First, Middles, Madden Surmanne) 10.0 Surgeturing Surest Surface (Surface) 10.0 Surface (Surface) 10.0 Surface (Surface) 10.0 Surface (Surface) 10.0 Surface) 10.0 Surface (Surface) 10.0 Surface (Surface) 10.0 Surface) Jersey	
Figure 1 2 Ceremation 3 Personal from State Glen Haven Cemetery 4/28/2006 Glen Burnie, Dual and Address of Facility Dual and Address of Facilit	. Inside City Limi 1 □ Yes 2 ☑ N
Security of the past of the	
FEBURIAL 2 Ceremation 3 Removal from State Glen Haven Cemetery 4/28/2006 Glen Burnie, 20 State 4 Donation 6 Ditter (Specify) Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 212 23a. Part Enter thy disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or head failure. Island to shook, or head failure. Island to shook, or head failure. Island to shook or head failure. I	Indian,
FEBURIALE 23a. Plate Lorente 1 1 23b. Plate	
Part 2 Commation 3 Removal from State Clen Haven Cemetery 4/28/2006 Clen Burnie, 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 79.22 Wise Ave. Dundalk, Maryland 21.2 Vision Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Maryland 21.2 Vision Name are substantially find the substantial of the su	
FEBURALE 23a. Part Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. An one of the part	·
Figure 2 Ceremation 3 Removal from State Glen Haven Cemetery 4/28/2006 Glen Burnie, Comparing the complete of the comparing the complete of the comparing the complete of the comparing the complete of the comparing the complete of the comparing the complete of the comparing the complete of the comparing the comparing the complete of the comparing the complete of the comparing the complete of the comparing the comparing the complete of the comparing the comparing the complete of the comparing	ode)
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head pathers. List only one cause on each line. Application Comparison	
23. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. A finding shock or head failure. Ist only one cause on each line. Immediate Cause (Final death) Immediat	•
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	nset and Death
24a. Was an autopsy performed? 1 Yes 2 No 3 Probable at 1 Yes 2 No 3 Probable 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 3 No 1 Yes 2 No 3 No 3 No 3 No 3 No 3 No 3 No 3 No	ıy Year
25. Was case referred to medical examiner? 1 Yes 28 No No No No No No No N	
examiner? Continue	findings availatetion of cause of
27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation 2 Accident Investigation 3 Suicide 6 Could not be	
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office 28l. Location (Street and Number or Rural Re	
building, etc. (Specify) City or Town, State) 29a. Certifier (Check only Check only 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	oute Number,
determined 286. Place of Injury - At nome, farm, street, lactory, office 291. Location (Street and Number of Hural Hold City or Town, State) 292. Certifier (Check only one) 192 (Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 293. Certifier (Check only one) 293. Certifier (Check only one) 294. Date signed (Month, Day 295. License number 296. Date signed (Month, Day 296. License number 297.	ed. e cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Res-00000 423/06	
The second of th	c, MD 212

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🖺 🦳 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician June O'Brien Smithson April 25, 2006 5:45 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore County Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2\ F Months Days Hours 78 July 11,1927 Director 577-32-3106 Washington, D.C Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County in then "natural", or Itema 23a or 28a-f eho The Modical Exponent must be notified at 1 No 2 No Maryland N/A Baltimore Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4816 Hamilton Ave. Apt.B 21206 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 20XNo Specify: Specify: White δ 3 ☐ Widowed 4 Z Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other then Elementary/Secondary (0-12) Macy's Dept.Store Sales Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be ind Mental I ၉ Peter Francis O'Brien Marguerite England Spieden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen Matthews (Daughter) 154 Greenmeadow Drive Timonium, Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 26, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 23a. Part. Enfer the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** paneventic Cancer disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Darther (Specify) NOSP(U 1 ☐ Yes 2 No ို ctor: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide o the Hospital 1 Sescertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D58303 APRIL 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles St Baramore MA Z1204 AARON CHARLES (NO) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

				For State Registrer	State	of Maryla	and / Depa <i>Ce</i>	artment o			d Mental		ene g. No. 0	6	13292
				1. Decedent's Name (First, Middle, La	ist)			-			2. Date of		Day	Year	3. Time of Death
_		Physici /Medic		Ralph Smith							April		2006	1001	7:10 p M
		Examin		4a. Facility Name (If not institution, gir	ve street and nu	mber)		4b. City, To	own, or L	ocation of D	eath		4c. County	of Death	r
				838 N. Eutaw Str					timo		Hea I a a				
		Funeral			Sex 1ÅM 2□F		rs. last birthday) 7 Yrs.	If Under 1 \ Months C	Days	Hours N	Ain. (Monti	h, Day,	Year)		place (State or Foreign
		Director		220-24-3130 Usual Residence of Decedent		77		1			May	24,	1928	Mar	yland
		yland yland		10a. State 10b. County		10c.	City, Town or Lo	ocation							10d. Inside City Limits
		Mar 9-1 st	į	MD			Balt	imore							1X Yes 2 No
		or 28	lre	10e. Street and Number				10f. Zip Co	ode			10	g. Citizen of	What Cou	ntry?
		23a 23a	Funeral Director	838 N. Eutaw St	reet	<u>.</u>		2120					USA		
		temes Firms	Jue	11. Marital Status	Armed F		10.S. 13.	Was Deceden If Yes, specify	nt of Hisp Cuban,	anic Origin? Mexican, Po	? (Specify Yes ouerto Rican, etc.	or No-		ce - Americk, White,	can Indian, etc.
	36	s efte	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi Year or [2 🔯 No		1 ☐ Yes 2	No No	Specify:			Specif	y: 1. 1.	1
	8	hour		15. Decedent's 8		Jales.	16a Dece	dent's Usual C	Occupati	on		1.	6b. Kind of B	bla	
	15	2 should be filed within 72 hours efter deeth with the Maryland and Mental Hygiene. Is marked other then "naturel", or items 23a or 28e-f show aumatic event, the Medical Examinal must be rollined at	Completed	(Specify only highest gi	ade completed)		(Give	kind of work of DO NOT use	done dui retired)	ring most of	working	'			
	212	y with	E O	Elementary/Secondary (0-12) unk	unk	1-4or 5+)	Facto	ry Wor	ker			P	ethle	em S	tee1
	פו	e filec of the vent,	BeC	17. Father's Name (First, Middle, Las	t)				1	8. Mother's	Name (First, M.				
	ılar	uld by Menta rked rice	ToE	Jacob O. Smith						Kathry	yn L. Jo	ohns	on.		
	ary	2 sho and h	ľ	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (S			Rural Route N			State, Zip	Code)
	Σ,	and 2 baith n 27		Mattie Jones/nie	ce					eld Ro	l. Balt:				
	ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [☐Removal from	1	cemetery, cre	sition (Name matory or othe	of er place)		Date	2	Oc. Location	- City or To	own, State
	Ë	Pages ment of ant: If its		4 ⊠Donation 5 ☐ Other (Spec	(y)										
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or iteme 23a or 28e-1 show with injury or other traumatic event, the Medical Examination at an angle.		21. Signature of Funeral Service Lice	- T. V - d	Direct	C	2. Name and A		D.	ard 655	T.7	Roltin	0.000	Stroot
		405 e a		June 1/1	Mall	PITECL	B	altimo	re,	$\frac{\text{My}}{\text{MD}}$ 212	201	W -	Dalli	ore a	
				23a. Fart1. Enter the disease or conspock, or heart failure. List only	one cause on	caused the de each line.	eath. Do not en	er the mode of	ot dying,	such as car	diac or respirati	ory arres	st,		Approximate Interval Between Onset and Death
,	1	Physician	7	Immediate Cause (Final disease or condition resulting in death)	a	cevel	provasc	war	ac	cide	nt -	STYC	Ke	1	unknown
Ja.		/Medical Examiner		resulting in death)		(or as a cons									50.50
30			40	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a cons	sequence of):		-					-	
7		ted nsit	Examiner	Cause (Disease or injury	500 15	(0.000000000000000000000000000000000000	304001100 017.								
		be executed sicien and burial-transit	xar	that initiated events resulting in death) Last	c. Due to	(or as a cons	sequence of):								
9	8760,	ate be executed hysicien and the burial-transit	al		d										
10	89		Physician/Medical		G.									ĺ	
0	Вох	eath certific ettending p	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pres		∃Ectopic preg						te of delive	ery ery
18	œ.	the ette	SICIB	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time o		Other (speci					Mo	onth	Day Year
1	0.	that the death ed by the etter detached for	λλ	9 🗆 Unknown					_		-				
1	S,	The law requires that the death certific Ne has been signed by the ettending p page 2 should be detached for use as	by	Part II. Other significant conditions	contributing to o	leath but not i	resulting in the u	nderlying cau:	ise given	in Part I.	1				he cause of death?
0	Records,	equir sen s	Completed	Seps 15							-	1 L Yes	2 □ No	3 Prob	pably 4. Onknown
7	G	law I	ple.					17			_	Was an autopsy	24b.	Were auto	psy findings available impletion of cause of
-	œ.		S								101	perform es 2	ed?	death?	2□ No
W	Vital	iicien: The lav certificete has rector, page 2	Be	25. Was case referred to medical examiner?	Hamitali						Death (Check o	only one)		Newson
5	of c		မ	1 ☐ Yes 2 ☑ No	-		ER/Outpatie			4 14013111	g Home 5				y) Hospice
	N C	ing Phys	Certification:	27. Manner of Death 1 ■ Natural 5 ■ Pending		of Injury oth, Day Year	28b. Time of Injury	M 280	Work?	at es 2 ∐No	28d. Desc	ribe nov	v injury occur	rea	
2	ivision	uttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not	OB Dies	o of Injuny - A	t home, farm, st			35 2 110	28f Locat	ion /Stre	et and Numi	ner or Pur	al Route Number,
à).	or Atten after deat Director: in by the	ertif	4 ☐ Homicide determined	build	ling, etc. (Spe	ecify)	eet, factory, o	JIIICO		City	r Town,	State)	767 07 11072	arriodie reamber,
Ralpi	_	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the		29a. Certifier 12 Certifying P	hvsicien: To th	e best of my	knowledge, deat	h occurred at	the time	date and p	lace, and due to	the cau	use(s) and m	anner as s	tated
0%		24 h	edical	(Check only 2 Medical Exa	miner: On the b	pasis of exam	ination and/or in	vestigation, in	n my opir	nion, death o	occurred at the t	ime, dat	e and place,	and due to	o the cause(s)
1		within To the	₹ E	29b. Signature and title of certifier				29c. L	License r	number		29	d. Date signe	d (Month,	Day, Year)
1				> 7As M)				DZ	4170		,	April 2	1,20	006
	•			30. Name and address of person who	completed cau	se of death (I	tem 23a) (Type,	Print)		1	Baltima			_/	~
	_				chey Ho	spice	gnature	N. Euct	Taw	St P	Baltima	re	MP	2120	01
	#	Sta		31. Date filed (Month, Day, Year) APR 2 7 2	006	Registrar's Sig	gnature	alle)							
¢2	Ba;	Registi	ar	HTK & 1 Z	100	Sof Fred &	and the								

		•	For State Registrar	State of	Marylan		artment tificate			and M	lental Hyg	giene leg. Nö.	06	13293
	Physici	an	Decedent's Name (First, Middle								2. Date of Dea	Day	Year	3. Time of Death
	/Medic		Sherwood Smit				4. 07.	-		15 1	April	20	2006	10304
	Examin	er	4a. Facility Name (If not institution		iber)				Location of	of Death		4c. Coun	ty of Death	
	Funeral		Union Memorial 5. Social Security Number		7. Age (In yrs.	last birthday)	If Under		if Under		8. Date of Birth	1	9. Birthp	lace (State or Foreign
	Director		215-38-1978	1 M 2 □ F	64	Yrs.	Months	Days	Hours	Min.	Sept 3,	, Year) 1941	Mary	itry)
	pu 🖢		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or Lo	eation				•			0d. Inside City Limits
	aryla •hov	٥	Md 100. County			altimo:								1 1 Yes 2 □ No
	28a-1	Director	10e. Street and Number				10f. Zip	Code			1	l 0g. Citizen of	What Cour	ntry?
	3a or	0	448 E. 22nd Sti	eet				2121	1.8			US		,
	death	Funeral		nk 12. Was Dece	dent Ever in U.	S. 13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)		ace - Americ ack, White,	
õ	or ite		1 Never Married 2 Marri	Armed For 1 Tes If Yes, Giv Year or Da	2 X No		1 ☐ Yes 2		Specify:	, 1 40110	, noun, oto.,		ily:blac	
9500-91212	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced		ites:	,	dent's Usua		tion					
Ċ	in 72	Completed	(Specify only highes	t grade completed)		(Give	kind of wor DO NOT us	k dane d	luring mos	t of worki	n <i>g</i>	16b. Kind of	business/inc	dustry
7	d with piene.	E O	Elementary/Secondary (0-12) unk	College (1 unk	-4or 5+)	fishe	erman					boa	ating	
פ	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle,	Last)			1	ınk	18. Mothe	er's Name	(First, Middle,	Maiden Suma	me)	unk
Maryland	- C	To												
Jar	~ ~ = 6		19a. Informant's Name/Relations								I Route Number			Code)
	1 and 1 Health 16m 27 other tr		Tom Smith/frier	ıd	20b. P	448 Place of Dispo			tree		ltimore,	MD 2 20c. Location	:1218	wn State
Baltimore,	Pages nent of I int: if its iry or o		1 Burial 2 Cremation		State c	emetery, crer	natory or or	ther place	9)			Edo. Edoation	ONY OF TO	mi, otato
	permit. Page Department of Important: if any njury or once.		4 □ Donation 5 ☒ Other (S)			_22	. Name an	d Addres	s of Facilit	γ .				
ä	Dep Imp		21. Signature of Euneral Service ROTALO	. Wade, 1)	irector	St Ba	tate A iltimo	Anato ore.	omy B MD	óard 2120:	655 W.	Baltin	nore S	treet
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that co	aused the deat					cardiac c	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one outside on or	* 0 = 6 = 1	Tabo	1 × 0/	100	Commen	0.6	CNI	(.)		Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	- CON 1021	-	angi	100)1	M(DI			2 Ness
	Examiner		Sequentially list conditions,	b. Sew	re le	oure-	GI	13	leedi	ng			1	2 day-
	sit ed	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				0				0
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c	or as a conseq	uence of):								
8760	death certificate be executed a attending physician and ad for use as the burial-transi	dical E												
0	ifficate g physi as the													
Rox	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pr	egnancy				1	ate of delive	•
	a dea ha att	sich	in the past 12 months? 1 Yes 2 No		ant at time of d		Other (sp					"	lonth	Day Year
J.	res that the de igned by tha a be detached f	Phy	9 ☐ Unknown Part II. Dther significant condition	TR contribution to de	ath but not ree	ulting in the u	ndorh/ing of	21160 6116	n in Part I		23e Did to	hacco use cor	atabuta to th	ne cause of death?
Š	signe d be d	by	Faith. Diller significant conduct	ins contributing to de	atti but not 165	ulang in the u	nderlying G	ause give	ni III Fall I		1 🗆 Y	./		ably 4 Unknown
Š	law requires as been sign 2 should be	Completed									24a. Was a			
ě	Φ - 0	dmo									autops	med?/	prior to cor death?	psy findings available mpletion of cause of
Vital Records,	iclan: Th certificate rector, pag	0	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	20000	1 🗆 Yes	2 No
	Attending Physician: or death, ector: After this certifice by the funeral director, p	To B	examiner? 1 Yes 2 Vo	Hospital:	patient 2	ER/Outpatier	nt 3 DO	Othe			me 5 Reside		ther (Specify	v)
Division of	iding Ph th, : After th : funeral	L:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of	of Injury h, Day Year)	28b. Time of	2	8c. Injury Work	at ?		28d. Describe h	ow injury occu	ırred	·
<u> </u>	uttendir death, ctor: Al y the fu	catle	2 Accident investig	ation			М		/es 2 □	No				
Ë	or Att	Certification;	3 Suicide 6 Could r 4 Homicide determ	ned 286. Place	of Injury - At he ng, etc. (Specif		eet, factory	, office			28f. Location (Si City or Town		iber or Rura	l Route Number,
ب	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a, Certifier 1 Certifyin	g Physician: To the	boot of my kno	wladaa daatl	n nonurred	at the tim	o date an	d place	and due to the e	21122(2) 224 2		atad
	To the Hospital within 24 hours and the Funeral completely filled	dical												
	To the	Me	29b. Signature and title of certifie	111			29c	. License	number	-	. 2	29d. Date sign	ed (Month,	Day, Year)
)			>). 1. Savai	ileh 1	1.1)		412	438	1946	~ F	40	4/2	20/06	5
			30. Name and address of person SHAHAB Tou	who completed caus R SAVAD 1	e of death (Item	1 23a) (Type,	Print)	teih	Ridge	e U	rck :	Baltimo	ne r	1D 21234
	Sta Registi	te ar	29b. Signature and title of certifier 5.7. Sovac 30. Name and address of person 5. HAHAIS Tov 31. Date filed (Month, Day, Year) APR 2 7 20	32. R	egistrar's Signa	ture	وع							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#9,10c,10e,20b, perFH (355,5/3/06 TT)

Amend item#9,10c,10e,20b, perFH (355,5/3/06 TT)

Amend item 9 per 1h g855,5/3/06 TT

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Singn PAPUL Saldeo 3:40A M 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOPKINS HOSPITO Johns Mare Ine If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Trinfd#d Tobago & Trinadad 5, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 → M 2 □ F 84 Director 4-23-22 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic svent, the Medical Examinar must be notified at Trinidad & TObago 1 Yes 2 □ No Director West Indies NA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Blythesville 2 Mile Mark Saddle Rd. Trinidad NA Completed by Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: East Indian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer PHD Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unkn Unkn ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TZTO511443 19th Avenue S.W., Calgary Alberta, Canada Son Brian Singh 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: if ite eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waterlou Mandin Cem. 5-1-06 Chaquanas, Trinidad Waterloo Mandin
22. Name and Address of Facility 21. Signature of Funeral Service Licenses 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ventric hours /Medical Due to (or as a consequence of): Examiner 40 Cardi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed coronary Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 280 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۴ 1 ☐ Yes 2 No this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation after death. Director: Af d in by the fur 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 🌿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ann 30. Name and address of cause of death (Item 23a) (Type, P 600 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 2

2006

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 6-50AM -2006 /Medical Facility Name (If not institution, give street and number) County of Death Examiner Date of Birth (Month, Day, Year) N/A Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F Hours 219-26-7576 68 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at Maryland Baltimore Towson 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 204 E. Joppa Road PH 11 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ρ 1956-59 White 3 ☐ Widowed 4 ☑ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 yr's Chauffeur Ruck Funeral Homes other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth eny lipiny or other traumatic event 9DRs. 18. Mother's Name (First, Middle, Maiden Sumame) Be Dominic Speranzella Antoinette Costantini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ron M. Speranzella - Son 1820 Pin Oak Drive Spring Grove, PA 17362 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp May 1, 2006 Towson, MD 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21214 eonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner reoplasma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 ANo Director: After this community in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Augustin Chyu m& 941 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Lock Paven Blvd. Bellimore. CHYU.M.D 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Certificate of	Death	Re	g. No.	10630
X	7	1. Decedent's Name (First, Middle, Last	0			2. Date of Death		3. Time of Death
Physic		7	William Gilbert S	pivev, Sr.		Month April	24, 200	6 10:25 A M
/Med Exami		4a. Facility Name (If not institution, give			r Location of Death	+	4c. County of	
	<u>a</u> ,	7208 Waldman Ave	nue	Edgem	ere		Balt	imore Co.
Funeral		5. Social Security Number 6. Se		thday) If Under 1 Year		8. Date of Birth (Month, Day,		9. Birthplace (State or Foreign Country)
Director		212-28-0331	⊠M 2□F 75	Yrs. Months Days		Nov. 19		Maryland
64		Usual Residence of Decedent			<u></u>	1100. 19	1230	riaryrana
ylan		10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
Mac	tor	Maryland Ba	altimore	E	dgemere			1 ☐ Yes 2 🗵 No
r 284	rec	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	nat Country?
3a o	0	7208 Waldman Aver	nue	21	219	1	United :	States
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Inter then "netural", or iteme 23a or 28a-f show ont, the Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H				- American Indian,
fer fer	Ē	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No			Rican, etc.)	Black	White, etc.
urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 21k No	Specify:		Specify:	White
72 hours "netural",	Completed	15. Decedent's Edi	ucation 16a.	Decedent's Usual Occup	pation	1	6b. Kind of Bus	
nin 7	pie	(Specify only highest grad	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of workin d))g		-
the plane	e e	12 Years	College (1-401 5+)	Welder			Steel :	Industry
at,	0	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		18. Mother's Name	(First, Middle, M.		
ld be enta	To B	Logan Oscar Si	oivev		Marymae	Lee		
s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. If the film 27 is marked other then "netural", or iteme 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at	-	19a. Informant's Name/Relationship (T		. Mailing Address (Street			City or Town, S	tate. Zip Code)
d 2 ith a 27 ts		Mrs. Lorraine Sp	oivey (Wife)	7208 Waldma	n Ave. Ed	lgemere,	Maryla	nd 21219
Head St	1.3	20a. Method of Disposition	20b. Place of	f Disposition (Name of	Da			ity or Town, State
permit. Pages 1 end 2 sh Department of Health and Important: if item 27 is m eny injury or other treum		t⊠ Burial 2 ☐ Cremation 3 ☐	Hemovai from State	ry, crematory or other pla	1			
rtan njur)		Donation 5 Other (Specify		Hill Mem. G				e River, MD
Depariment of the parameter of the param	1	21. Sunature of Funeral Service		Luda-kuc	ss of Facility K Furieral	Home of	Dundal!	k, Inc.
46240			Call	7922 Wis	e Ave. Du	ndalk, N	Marylan	
		23a. Part1. Inter the disc ase, or comp shock or heart failure. List only of	dications that caused the death. Do none cause on each tine.				st,	Approximate Interval Between
Physician	11	Immediate Cause (Final disease or condition	Circhosis	of live	V			Onset and Death
/Medical		resulting in death)	Due to (or as a consequence	of Live Hyponat	P=s			
Examiner		Construction to the constitution of	Chronic	Huponat	rema			
	Je	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
cutec	Examiner	that initiated events	. Fluid ove	rload				- 4
exe exe an ar rial-t	EX	resulting in death) Last	Due to (or as a consequence	of):				
certificate be executed iding physicien and ise as the burial-transit	C S		d.					
ificat g phy as th	/Medical	_						
	100	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date	of delivery
d for	Physiciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnanc; 5 ☐ Other (specify) _	у		Mont	
the cy	Jysi	9 Unknown	9□ Unknown					
w requires that the death of the signed by the attenshould be detached for u		Part II. Other significant conditions co	entributing to death but not resulting is	n the underlying cause giv	ven in Part I.	23e. Did toba	acco use contrib	oute to the cause of death?
sign d be	d by					1 🗌 Yes	2 12 No 3	Probably 4 Unknown
pe de la la la la la la la la la la la la la	Completed					-		
has has e 2 s	ldr					24a. Was an autopsy	24b. W	ere autopsy findings available or to completion of cause of ath?
The cate	Ö					perform 1 Yes 2	Ø7 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	atn? Yes 2 No
cian	Be	25. Was case referred to medical examiner?			26. Place of Death	Check only one	1	
hysi his c	ု	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Ott	1er: 4 ☐ Nursing Hom	ne 5 Resider	nce 6 Other	(Specify)
fer t	Ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending		Time of 28c. Injury Wo	ry at 2 rk?	8d. Describe how	w injury occurre	d
ath.	ati	2 Accident investigation			Yes 2 □No			
er der der der der der der der der der d	Ħ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	2	8f. Location (Stre	eet and Number	or Rural Route Number,
s after so do in be	Certification:	,	building, die. (opeany)			ony or . own,	Olato)	
pspit hour ner y fill		29a Certifier 1 Certifying Phy	ysinian: To the best of my knowledge	Jesth Jeeumad at tha ti	me, data and plana, a	nd due to the eau	ueo(s) and man	nor ac statud.
To the Hospitel or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u.	edicai	(Check only 2 Medical Examone)	iner: On the basis of examination an and manner stated.	lazor investigation, in my o	pinion, death occurre	od at the time, dat	te and place, ar	id due to the cause(s)
To the To the To the Comp	ž	29b. Signature and title of certifier	1. 1	29c. Licens	se number	29	d. Date signed	(Month, Day, Year)
		1 Manda	iralis mb	D	003634	13	4/2	51200C
5		30. Name and address of person who d	completed cause of death (Item 23a)		-0-0-1		1	
7			KS 4920 Campbel		ite Marsh,	Marylan	ıd	
to the State of Co	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		-			

DHMH 17 Rev 1/2001

State Registrar fraile

APR 2 7 2006

Registrar

DHMH 17 Rev 1/2001

Michael Siebert 06-02322 Please Type or Print in Black Indelible Ink UNK, UNK State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Da April 4, 2006 **Medical Examiner** SIEBERT 11.27 MICHAEL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director N/A 1[X] M 2 F NOV. 24,1957 48 Usual Residence of Decedent any. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 X Yes 2 No MD. N/A BALTIMORE permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Market at once. 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? or items 23a or 28a-UNKNOWN UNKNOWN U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: WHITE 2 or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) **Baltimore, MD 21215-0036** N/A DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WES ROBISON/ FRIEND 1000 FELL ST., APT. 614, BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ST. STANISLAUS CEMETERY 4/18/06 BALTIMORE, MD. Donation 5 Other Specify. LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Arteriosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED item#23a,27,perME,g855,5/1/06 TT attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed?
1 ✓ Yes 2 No death? 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 00A Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) Unknown 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Unknown Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide

21231

29d. Date signed (Month, Day, Year)

April 5, 2006

24 hours after death. Funeral Director:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)

APR 2 7 2006



111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item / per fh 854 4-27-06 vt

			1 - For State Registrar		ryland / Depa <i>Ce</i>	rtificate of		R	eg. No.	13299
	Physici		Decedent's Name (First, Middle, La LOIS	s <i>t)</i>		SILVER	RERG	2. Date of Dea Month APRIL	Day Year 24 2006	3. Time of Death 5:55 P M
†	/Medio		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Dea		4c. County of Deatl	
			WESTMINSTER NURS 5. Social Security Number 6.5		(In yrs. last birthday)	WESTMINS If Under 1 Year	TER If Under 24 Hr.	S. 9 Date of Birth	CARROLL	nplace (State or Foreign
	Funeral Director			G., -G-	102 Yrs.	Months Days	Hours Mir		(Year) Co.	PA
and	>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Mac	of e h	to	MD CARR	OLL	•	STMINSTER				1 ☑ Yes 2 ☐ No
th the	or 28s	Directo	10e. Street and Number			10f. Zip Code			0g. Citizen of What Co	•
a die	nust b		1234 WASHINGTON	ROAD 12. Was Decedent E	ver in II S 12	Was Decadent of h	2115		14. Race - Amer	USA ican Indian
USO urs after de	el', or Item Examinar	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	0	1 Yes 2X No	Specify:	Specify Yes or No- rto Rican, etc.)	Black, White	
1 Z 1 D-UUSO within 72 hours after death with the MacAland	tal Hygiene. d other than "naturel", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of we	orking	16b. Kind of Business/f	ndustry
Id A	other other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle,		
ar y lai	Menta Merked Matic e	To E	WALTER	JAY		RBERG	GOLD			LABELLE
Maryland 6121	th and 17 le m traum		19a. Informant's Name/Relationship (SHIRLEY HANDELS			•			r, City or Town, State, Z RE, MD 2121	. ,
, j	Item to	j	20a. Method of Disposition		20b. Place of Dispo		Ţ		20c. Location - City or	
barrimore,	tant: If	l	1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	y) 1	CARROLL C	CREMATION	INC 04/	26/06	HAMPSTEAD,	MD
ם מ	Deportment Important: Pany o		21. Signature Funeral/Service	Vilian		2. Name and Addre	STERSTOW	N ROAD -	ISON & BROS PIKESVILLE	, MD 21208
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each line	the death. Do not ent					Approximate Interval Between Onset and Death
1	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	wi ac	anh	nt Im Dis		3 down
E	xaminer	_	Sequentially list conditions,	b. arti	consequence of):	esotu (Janen	lm Dis	une	30y
Culted	sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. atr	much	age	_			100 typ
ficate be executed	physicien s the burial	edicai E		d	consequence of):					
The law requires that the death certific		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 10 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	′		23d. Date of deli	very Day Year
JS, F.	signed by	ρ	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Vital Records,	s been si	ojetec						24a. Was a	n 24b. Were au	opsy findings available
		Completed						autops perfore	med? death?	omptetion of cause of 2 No
VILC	nis certificate I director, pag) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ⊅o	Hospital:		- 3C 004 Oth		eath (Check only or		
5 2	h. After this funeral d	n: To	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time o	IL 3LI DOA	y at		ence 6 Other (Spec ow injury occurred	ity)
DIVISION OF VITA	efter death. Director: Af in by the fur	Certification:	1 Naturat 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of Injur	ry - At home, farm, sti	M 1 🗆	Yes 2 □ No	28f. Location (Si City or Town	treet and Number or Ru	ral Route Number,
Hospital or	within 24 hours efter of To the Funerel Direct completely filled in by			building, etc.		h occurred at the ti	ne date and place		ause(s) and manner as	stated
e H	n 24 h he Fun pletely	Medical	(Check only 2 Medical Example)	niner: On the basis of and manner stat	examination and/or in	vestigation, in my o	pinion, death occ	curred at the time, d	ate and place, and due	to the cause(s)
T of	To t com	Σ	29b. Signature and title of certific	1114		29c. Licens	e number)	9d. Date signed (Month	4
,	,		30. Name and address of person who	completed cause of de	ath (Item 23a) (Tues-	Print	L) YY	5	7/25/2	021157
	6		ILL W. MIA	defon	488 10	ole To	ead h	testin "	ista M	0215)
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Begistra	r's Signature	1			•	

	1	For State Registrar	State of Ma	aryland		artment of F		d Mental Hy	giene Reg. No.	006	13300
Physicia	n	1. Decedent's Name (First, Middle, Last)		ς				2. Date of De Month	ath Day	Wor Year	3. Time of Death
/Medica Examine	r	4a. Fecility Name (If not institution, give s			19 W-	4b. City, Town, o		eath M0 3133	4c. 0	County of Death	N/A
Funeral Director		5. Social Security Number 6. Sex	7. Age	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Ain. 8. Date of Bir	th y, Year)	9. Birth	place (State or Foreign intry) Maryland
and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				T	10d. Inside City Limits
Maryi -f eho	5	Maryland N	/A	-		E	Baltimore				1 Yes 2 No
with the	by Funeral Director	10e. Street and Number 502 Seagull Avenue				10f. Zip Code	21225	5	10g. Citiz	en of What Cou	
death	era		12. Was Decedent 8	Ever in U.S.	13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No	- 1	4. Race - Amer	
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or lieme 23e or 28e-f ehow he Masical Exemplest must be notified at	by ru	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ ★ If Yes, Give Year or Dates:	40		fYes, specify Cuba I∐Yes 2∐ X io	Specify:	uerto Hican, etc.)		Black, White Specify:	, etc. Black
72 ho	ed -	15. Decedent's Edu (Specify only highest grade				lent's Usual Occup		working	16b. Kin	d of Business/li	ndustry
within then.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	OO NOT use retired	memaker	Working		Own	Home
and 2 Ibe filed Intel Hygi of other event, It	e a	12 17. Father's Name (First, Middle, Last) Charles	Bowers				18. Mother's I	Name (First, Middle,	Maiden S allie La		
should be mark mark imatic	0	19a. Informant's Name/Relationship (Ty			19b. Mailin	g Address (Street	and Number or	Rural Route Numb	er, City or	Town, State, Zi	p Code)
, Ma and 2: saith an n 27 le		Calvin M. Thomas Husb	and				ugusta Ave	enue Baltimore	e, Mary	land 21229	9
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23s or 28s-f show eny injury or other treumatic event, the Madical Examinat mast be notified at once.		20a. Method of Disposition 1 ☐ X urial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Plac	netery, cren	sition (Name of natory or other place) Zion Ceme		Date 04/29/06		ation - City or T Lansdowne	own, State e, Maryland
Balti permit. Depertir Importe eny inju		21. Signature of Juneral Service License	· Est	9	22	Name and Addre	ss of Facility Brothers F	uneral Service e Baltimore, M	P. A.	17	
	\top	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death.	Do not ent						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition				RILUME					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as:		nce of):						
	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	_	nce of):						
Cuted nd ransit	Examiner	triat irritiated events	PNEU								
icate be executed physicien and sine burial-transit	a Ex	resulting in death) Last	Due to (or as a			87168	- Foun	C.			
687 tifficate ng phys as the	edical		l	-7///		6///6	. , , , , , ,				
Box eath cert attendin for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)	,		2:	3d. Date of delive Month	rery Day Year
s that the need by	y r	Part II. Other significant conditions con	ntributing to death bu	ut not resulti	ing in the ur	nderlying cause giv	en în Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
cords w require: been sig should bu	9	HUROTHYMOID	ANE	MIH				_ 1□'	Yes 2□	No 3□Pro	bably 4 Unknown
Division of Vital Records, P.O. I or Attending Physicien: The law requires that the defler death. Director: After this certificate has been signed by the tin by the funeral director, page 2 should be detached.	Completed	CACHEXIA					-			24b. Were aut prior to co death?	opsy findings available ompletion of cause of
		25. Was case referred to medical examiner?					26. Place of	Death (Check only of		1 163	
n of Vitaling Physician: g Physician: ter this certifical neral director.	0	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie 28a. Date of Injur (Month, Day	ry 2	NOutpatien 8b. Time of Injury		4 🗆 14013111	g Home 5 ☐ Resi			fy)
SiOr eath. or: Alt	Satio	Natural 5 Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Yes 2 □No				
Divis	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At home c. (Specify)	e, farm, str	eet, factory, office		28f. Location (City or To		Number or Rui	al Route Number,
	edicai	29a. Certifier Check only one) Certifying Physical Examination	ner: On the basis of and manner sta	examination	edge, death n and/or inv	restigation, in my o	ne data and pl pinion, death o	aca, and dua to the occurred at the time,	date and p	and marker as place, and due	stated to the cause(s)
To th within To th compl		29b. Signature and title of certifier	000 1-1			29c. Licens	e number		29d. Date	signed (Month	Day, Year)
		I Janet V- We	egu reli.	, MJ		D)	47 49		4/	21/200	06
9		30. Name and address of person who co	mpleted cause of de	eath (Item 2	3a) (Type,	Print) 7000	DW.	PRITIE	MA	2177	ce 7
Stat Registra	ت ا	30. Name and address of person who co JAME7 V- MWE 14 31. Date filed (Month, Day, Year) APR 2 7 21	32. Régistra	ar's Signatur		sels.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 447 PM James Ur banski lohn 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death AUTOMORIOSEAT los BALTIMORE OAY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days Hours 1 M 2 □ F Yrs. MARYLAN Bi-SUA 313-18-0032 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Charagan BALLIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code NUS KIODERROAD A. 91337 2805 AF 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3€ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) axolanz 712, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) AREYADDA IATEL KA ANTHONY URBANOWICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARBARAE SUDE ONALVIA'I STOPTIZAD 3401 FILL (10FO) MALVHERI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State APRIL 23 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LIK TEXTON 21. Son turn of Furnital Service License 22. Name and Address of Facility = NEM EE16 REMORIES IAMPAN FAR HUILDE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial 5 MINUL Due to (or as a consequence of): Cardiovascular Atherosclerohc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24a. Was an

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

Funeral

Director

r 28a-f show

r than "natural", or items 23a or the Medical Examiner must be in

be filed within 72 hours after de tal Hygiene d other than "natural", or Item

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Importent: If Item 27 is marked other any injury or other treum....

Directo

Funeral

ģ

Completed

the Maryland

Examiner signed by the attending physician and be detached for use as the burial-transit Physician/Medical signed by Completed by been si certificate Be ပ this After thi

The law requires that the death certificate be executed

Attending Physician:

death.

To the Hospitel within 24 hours a To the Funerel C

after

the t Director:

filled in by

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant 1 ☐ Yes 2 ☐ No 9 Unknown

examiner'

1 Yes

27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

25. Was case referred to medical

2 No

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 2 🗌 No

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE

29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number and title of certifier

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 038675

- 24- 2006

MD

PAUL PL 4605 JOEL MESHULAM 301 57 31. Date filed (Month, Day, Year) APR 2 7 2006 32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Certification:

Medical

		,	For State Registrar		State	of Maryla	and / Dep <i>Ce</i>	artmen rtificat				lental Hy	giene Reg. No	000	13302
	Physicia	an	1. Decedent's Name (First, M.	ddle, Las	st)							2. Date of De Month	Da	y Year	3. Time of Death
	/Medic	al	WILLIE	C.		ILLIAM	S		-	1	45	apri			
	Examin	er	4a. Fecility Name (If not institu	ition, give	street and nu	imber)		ABERI		Location of	of Death	1		. County of De <i>a</i> HARFORD	th
	Funeral		71 SWAN ST 5. Social Security Number	6. S	өх	7. Age (In y	rs. last birthday)	If Under	1 Year	If Under		8. Date of Bir	rth	9. Bir	thplace (State or Foreign
	Director		267-05-4726	1	□M 2[XF	8	5 Yrs.	Months	Days	Hours	Min.	(Month, Da			RGIA
	pu ,		Usual Residence of Decedent 10a. State 10b. Cou			100	City, Town or L	ocation							10d. Inside City Limits
	fanyla show	JO.				100.									1 ☐ Yes 2 🛣 No
	28e-f	Director	MD HAR 10e. Street and Number	FORD			ABE.	RDEEN 10f. Zip	Code				10g. Cit	tizen of What Co	ountry?
	3a or		71 SWAN ST						2100	1			U.S		,
	deatl	Funeral	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.				igin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit	
õ	hours after death with the Maryland turel', or flems 23a or 28e-f show at Examinar must be notified at		1 Never Married 2 1		1 ☐ Yes If Yes, G	2 X No ive		1 ☐ Yes		Specify:				Specify:	
215-0036	in 72 hours after death with the Marylar "natural", or Items 23a or 28e-1 show selical Examinar must be molified at	ed by	3 X Widowed 4 ☐ Divor		Year or I	Dates:	163 Dece	dent's Usua	N Occupa	ation			16h K	and of Business	BLACK
င်	I within 72 ho liene. r than "natui r e Medicel	Completed	(Specify only hi	ghest gra	de completed		(Give	kind of wo DO NOT us	rk done d	durina mos	t of work	ing	160. K	and or ousmess	industry
717	yiene.	шо	Elementary/Secondary (0-1	2)	College	(1-4or 5+)	NURS	ING AS	SSIS!	TANT			NUI	RSING	
g	be filed tal Hygi d other event, I	Bec	17. Father's Name (First, Mide	de, Last)						18. Mothe	er's Name	e (First, Middle	, Maiden	Sumame)	
Maryland	nould be I Menta narked natic ev	To	UNKNOW	IN						GUS	SIE	GRIFFI	1		
Jar	2 st and Is n		19a. Informant's Name/Relati											or Town, State, .	Zip Code)
	i and fealth em 27 ther t		CLEONIS WILLI 20a. Method of Disposition	AMS	JR./ So		4103 D. Place of Dispo			DR. L		VILLE, F		40216 ocation - City or	Town State
20	Pages nent of H int: If ite iry or of		1 ∑X urial 2 ☐ Cremati			State	cemetery, cre	matory or o	ther plac						
Baltimore,	permit. Pages Department of Importent: If i any injury or o		' 4 □ Donation 5 □ Othe			15.	T. JAME:				-26- v				RACE, MD
œ M	Depire Impo		MAI las	/	1/_			Willia 321 S	am C	. Bro ilade	wn C lphi	omm. Fu	inera Abe	al Home- erdeen.	-Harford P.A MD 21001
			25a Fart1. Enter the disease shock, or heart failure.	, or com	ications that	caused the de					_			•	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Con	to	no The	- 0	l		- 1	a d	ر ا سام	دحمد	Onset and Death
	/Medical		resulting in death)		Due to	(or as a cons	sequence of):			NO VON	Tare		- per		
Н	Examiner	_	Sequentially list conditions		b										
<u></u>	bed issit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to	(or as a cons	sequence of):								
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last		c. Due to	(or as a cons	sequence of):								
9/	ysiciar he buri	calE		l	d										
89					· ·										
Rox	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, or 1 ☐Live	utcome of pre- birth 2 ☐ F		□Ectopic pr	egnancy					23d. Date of de	livery Day Year
O. E	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nant at time o		Other (sp						MORUT	Day rear
<u>.</u>	The law requires that the tee been signed by the base been signed by the bage 2 should be detache	Phy	Part II. Other significant con	ditions c	ontributing to	death but not	resulting in the I	inderlying c	ause dive	an in Part I		23e. Did 1	tobacco	use contribute to	the cause of death?
ecords,	signed by deta	d by	N	ne_					g						robably 4 Unknown
000	w require been sig should b	lete										24a. Was	an	24b. Were au	utopsy findings available
Ř	The law cate has page 2.	Completed										auto perfe	psy ormed?	prior to death?	completion of cause of
Vital		Φ	25. Was case referred to med	tical	-					26. Place	of Deatl	1 Yes	2 No one)	1 ☐ Yes	No No
	S 0 :D	To B	examiner? 1 A¥ es 2 ☐ No		Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DC	Othe			900		6 ☐Other (Spe	city)
n of	<u>a</u> = <u>a</u>		27. Manner of Death 1 Natural 5 ☐ Pe	ndina	28a. Date (Mo	of Injury oth, Day Year	28b. Time of Injury	of 2	8c. Injury Work	at c?		28d. Describe	how inju	ry occurred	
20	otor: A y the fu	catl	2 Accident inv	estigation				М		Yes 2	-		· · ·		
Division	or Attendath after death Director: /	Certification:		emined	259. Flat	e of Injury - A ling, etc. (Spe	t home, farm, st ecify)	reet, factory	, office			City or To			ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 ☐ Cert	fvina Ph	vsician: To th	e best of my l	knowledge, deal	h occurred	at the tim	ne. date an	d place.	and due to the	cause(s) and manner as	s stated.
	e Hos 24 h e Fur letely	Medical			niner: On the										to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Me	29b. Signature and title of cer	tifier	11 .			290	. License	number			29d. Da	te signed (Mont	h, Day, Year)
			1 2 mul	4/1	In MI	O, DE	4	J	100	14	201	6	am	ul 26.	2006
	12		30 Name and address of pe	on who	completed cau	of death (I	tem 23a) (Type	-	111)	11	/	A 9 1	1	0.	2006 Md 2122
	12		ALM WA	1-	YUKI 32.	Begiştrar's Si	11,11MZ	- 10	118	HOL	ABI	rd Al	L	DALTO	Md 2122
	Sta Registr		31. Date filed (Month, Day, Y		200	yışırar s Si	griature								
			APRA	1 21	JUD I. A	The sale of	All and and	TO THE MANAGEMENT	7						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#22, perFH, 9854, 4/27/05 IT
State of Maryland / Department of Health and Mental Hygiene () () 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Vernon Lee Weaver Apr. 1 12:50 AM 24 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Battimote City
If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Sina Hospital
5. Social Security Number 6. S of Baltimose N/A 8. Date of Birth (Month, Day, Year) 51 9. Birthplace (State or Foreign Country) Va 6. Sex 7. Age (In yrs, last birthday) 219-58-4559 12 M 2□F 54 Yre Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits MD N/A Baltimore 1 SYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 2702 Keyworth Ave Apt# T 10 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Chef Army 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Eleanor Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21208 Rhonda Pannell-Weaver/Wife 7201 Brook Crest Way Apt B4 Baltimore MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Cem 5/3/06 Owings Mills MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris 1 Home 5240 Reisterstown Rd Baltimore MD 21215 18 aires eroy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vneumocystis Carini Due to (or as a consequence of): Renal Fanloix Chronic Coquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Diabetes autopsy performed? 1 Yes 24 No 25. Was case referred to medical examiner? 26. Place of Death |Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide

Physician /Medical Examiner The law requires that the death certificate be executed Box 68760 o. Records. Division of Vital or Attending death.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f ehow

r than "natural", or iteme 23s or the Medical Examinar must be

nd Mental Hygiene.

.

permit. Pages 1 end 2:
Department of Health at Important: if item 27 is any injury or other trau

and I-transit

physician ar

the

ģ signed i

certificate

this

After thi funeral c

Director:

Physician/Medical

þ

Completed

٩

Certification:

1 and 2 should be Health and Mental

Grad as

Director

Funeral

Completed by

To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by Medical

DHMH 17 Rev 1/200

State Registrar

29b. Signature and title of certifier

4 Homicide

29a. Certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas

terifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RES-000

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24.2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician Medical Examiner Julia M. White Month 4 17 2006 O105a			,		State of	waryia		•		Death		ontai riy	Reg. No.	36	13304
March Province Common Control Common Control Common Control Common Control Common Control Common Control Common Control Common Control Common C	Physi	⊭ ician	Decedent's Nar	ne (First, Middle, La	st)						1			Year	3. Time of Death
## Season of the County of Danie County of Dan														1001	0105a
Social Scrutzly Number S. Seed Scrutzly Number S. Seed Scrutzly Number Seed Scrutzly	1		4a Facility Name	(If not institution, giv	e street and num	ber)				4b. City, To	wn, or Loca	ation of Deat		ty of Death	,
Social Scrutzly Number S. Seed Scrutzly Number S. Seed Scrutzly Number Seed Scrutzly			Unive	rsity of M	Marvland					Ra l	timor	-0		NI /A	
23.1 - 5 - 0.226 1D w 2026 31 vs. Mortille Days Hors Mr. Mortille Days Hors Mr. Mortille Days Hors Day	Supero	1			*	. Age (In vrs	s. last birthda	(V) If Und	der 1 Year			_	th		lace (State or Form
100. State and Number 100. Construction 100. From or Location 100. From			231-15-0	226 1				Month	s Days	Hours	Min.				
The second continues of the se	D					100 0	ity Town or	Location			<u> </u>				Od Jasida City Line
The second continues of the se	e Maryli e-f sho	ctor													1 1 Yes 2 □ N
The second continues of the se	E 23	<u>ē</u>	10e. Street end No	umber				10f. 2	Zip Code				10g. Citizen of	What Cour	itry?
The second continues of the se	38 4		1521	N Gilmor	Street				212	17			T.70	C A	
The second continues of the se	age of a state of a st	678		W. OIIMOI		ent Ever in I	115 1	3 Was Dec			ain? (Spec	ify Voc or No			an Indian
Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA NA Disabled NA NA Disabled NA Disabled NA Disabled NA Disabled NA NA Disabled NA Button Device of the property of the place of the property of the place of		5		ried O Atomical	Armed Ford	es?	0,0.	If Yes, sp	pecify Cub	an, Mexican	, Puerto Ri	ican, etc.)	Bi	ack, White,	etc.
Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA NA Disabled NA NA Disabled NA Disabled NA Disabled NA Disabled NA NA Disabled NA Button Device of the property of the place of the property of the place of	25 = 1				If Yes, Give	XXvo		1 ☐ Yes	2 No	Specify:			Spec	ifv: ¬¬	
Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA NA Disabled NA NA Disabled NA Disabled NA Disabled NA Disabled NA NA Disabled NA Button Device of the property of the place of the property of the place of	8 5 1	9	3 🗆 ANIGOMAG	4 LI Divorced	Yeer or Dat	es:								BTS	ack -
Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA Disabled NA NA Disabled NA NA Disabled NA Disabled NA Disabled NA Disabled NA NA Disabled NA Button Device of the property of the place of the property of the place of	# 2 0r	흥	(Spe	15. Decedent's Ed	lucation de completed)		16a. De	cedent's Us	sual Occup	oation during most	t of working	7	16b. Kind of I	Business/Ind	dustry
Orville White Dorong Final Service Licenses (Speech of Speech) Playsician Manual Cause Final Service Licenses (Speech of Speech) Playsician Manual Cause Final Service Licenses (Speech) Playsician Manual Cause Final Manual Cause Final Service Licenses (Speech) Playsician Manu	7 전 돌 등 등 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기 기	혈				for 5+)	life			d)					
Orville White Dorong Final Service Licenses (Speech of Speech) Playsician Manual Cause Final Service Licenses (Speech of Speech) Playsician Manual Cause Final Service Licenses (Speech) Playsician Manual Cause Final Manual Cause Final Service Licenses (Speech) Playsician Manu	수 선 출발투표	Ž	9th					Disa	pled				NA		
The maining hadress (Simel and Momber of Date (Prop. Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and Momber of Pinst) The Maining Address (Simel and	3 口 意味		17. Father's Neme	(First, Middle, Last)						18. Mothe	r's Name (First, Middle,	Maiden Surna	ıme)	
Daryle White—brother 288 Kentucky Avenue Baltimore, MD 21212 200. Method of Disposition (American States) (American States) 200. Method of Disposition (American) (American States) 200. Method of Disposition (American) 21. Signature of Linearis Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME—FAST 21. Signature of Linearis Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME—FAST 23. Method and the service Licensee 24. Name and Address of Facility MARCH FUNERAL HOME—FAST 25. Name and Address of Facility MARCH FUNERAL HOME—FAST 26. Name and Address of Facility MARCH FUNERAL HOME—FAST 27. Name and Address of Facility MARCH FUNERAL HOME—FAST 28. Part Liter the disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Approximate disease or spiral properties of the caused of the east of the caused	T die	0	Orrei 1	lo Whit						_					
Daryle White—brother 288 Kentucky Avenue Baltimore, MD 21212 200. Method of Disposition (American States) (American States) 200. Method of Disposition (American) (American States) 200. Method of Disposition (American) 21. Signature of Linearis Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME—FAST 21. Signature of Linearis Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME—FAST 23. Method and the service Licensee 24. Name and Address of Facility MARCH FUNERAL HOME—FAST 25. Name and Address of Facility MARCH FUNERAL HOME—FAST 26. Name and Address of Facility MARCH FUNERAL HOME—FAST 27. Name and Address of Facility MARCH FUNERAL HOME—FAST 28. Part Liter the disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Do not enter the mode of dying, such as cardiactor respiratory arrest. Approximate disease, or completations, that caused the eeath. Approximate disease or spiral properties of the caused of the east of the caused		F					405.84		(0)						
1 Special and Committed 1 Special and Committed	Zad A													n, State, ∠ip	Code)
1 Special and Committed 1 Special and Committed	0				ther		28	88 Ke	ntuck	y Ave	nue B	Baltimo	ore,MD	2121	2
Committee Comm				•		20b.	Place of Dis	position (N	lame of r other plac	ce)	1	Date	20c. Location	- City or To	wn, State
22. Name and Address of Foolity MARCH FUNERAL HOME-RAST 1101 E. NORTH Avenue Baltimore, MD 21202 23a. Part I, Either the diseases, or reading the death. On not enter the mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying, such as cardiac or respiratory arrest. Approximate mode of dying as a consequence of): But to (or as a consequence of): But to (or as a consequence of): Consequence of): But to (or as a consequence of): Consequence of): But to (or as a consequence of): Conseque	Z E Ba E E		4 ☐ Donetion	5 Other (Specific	Hemoval from St						4/	22/200	06 Bali	timore	e MD
Physician Phys		4									1				
Physician (McGical Examiner) 23a. Part I. Enter the diseases, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, including an interval Between Onset and Death Interval Bet	A B S S S S S S S S S S S S S S S S S S		1	100	-		-				MAR				
Physician (Redical Examiner) Total Content and Death Content			F	I lade	p W	ane		1101	E. N	IORTH .	Avenu	e Balt	imore,	MD	21202
Due to (or as a consequence of): Sequentially list conditions, if erry, leading to minesiate constitutions are consequence of):	/Medical		Immediate Cause	(Final	one cause on each	used the dea th line.	ath. Do not e	enter the mo	ode of dyin	R i	cardiac or i	respiratory a	rrest,	!	Approximate Interval Between Onset and Death
d	- Examine.		resulting in death)			Due to ((or as a cons	sequence of	f):						
d	n =	- E			Mor	bil	150	situ							you
d	// se ca	Ē	Sequentially list or	anditions C	b		for es a cons	equence of	n.	· · · · · ·					100
d	A 200 Parties	EX	if eny, leading to it	mmediate	Hu	1 11	(0) 00 0 0013	/	η.						
d	50 % Solar	- G	Cause (Disease of	rinjury	c	12011	yro	dis	n-					-	42
d	8 th	ğ	resulting in death)	Last		Due to (or as a cons	equence of):					1	
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	X grad				d									i_	
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	O the state	<u>e</u>		_										1	
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	de de de de de de de de de de de de de d	3	Part II. Other signi	ficant conditions co	entributing to deat	th but not re:	sulting in the	underlying	cause giv	en in Part I.		23b. Did 1	obacco use co	ontribute to	the cause of deat
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	O. Tithe	훚							_			10	Vac 2□No	3□ Prob	ably 4.241nkno
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	the de de de	<u>></u>											.05 20110	00.100	420
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	d black	무										24a Was	an autoney	24h We	re autonsy findings
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	O Per Per Poly	e e										perfo	med?	ava	ilable prior to
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	law law	ᅙ													
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	F T T T T T T T T T T T T T T T T T T T	듓										101	es 2 No	10	Yes 2□ No
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	the En	9	25. Was case refe	rred to medical					•	26 Place	of Death (Check only a	ne)	_1	
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236		0	examiner?		Hospitel:	atient of] EB/Owner	ent all	Oth	or:				has 10- "	-
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	P P si la	Ę							JOA	4LI NUI					7
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	Ing Hade	5	1 Natural	5 Pending	(Month,	Dey Year)							iow injury occu		
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	Sic eath or: /	Cat								τes 2∐N					
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	V A C	Ť.		determined	Zoe. Flace of	Injury - At h	nome, farm, s	street, facto	ry, office		281	f. Location (S	Street and Num	ber or Rura	Route Number,
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236		ë				()	**					, o, ron	,,		
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	Hospit 24 houn Funera	dlcai ((Check only	1 Certifying Phy 2 Medical Exam	iner: On the basi	s of examine	owledge, dea	ath occurred investigation	d et the tim	ne, date and pinion, deatl	plece, and h occurred	d due to the o	cause(s) and m	anner as sta	ated. the cause(s)
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 611, South Charles Street Baltimere, MD 21236	# the	2		title of socidies	and manner	stateU.		1 ~	Oc Lines	n Dumb			and Date :	(0 4 - ···	2 V
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, MD, 61/ South Charles Street Baltimere, MD 21236	6 출 6 월	-			n4 12						,		A L - /	1 St	ray, Year)
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (HARY MEHTA, M), 611, 50 Th Charles Street Baltimere MD 21236			P 017	rental	1-01)				،ک رے	47)	4	1	HPMI	~ '	2006.
31. Dete filed (Month Day Year) 32 Registrer's Signature	-		30. Name end addr	ress of person who o	ompleted cause o	of death (Item South (m 23a) (Typi	e, Print)					MDZ	1236	
			31. Dete filed /Mon	th. Day, Year)	35 Ren	istrer's Sign	ature A	460	·						

06-02467	
White, Garry	

Phys Medical Exa

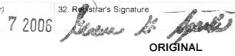
Please Type or Print in Black Indelible Ink

te, Garry		Sta 1- For State Registrar	te o	f Maryla	and /		rtment of dificate of		and	Menta	l Hyg		eg. No.	200	6	133	0
Physicia dical Exami	an/	Decedent's Name (First, Middle, Garry	Last)	Garry	Edw.	in Whi	te ite					Date of Dea Month April 11, 2	th Day	Year	3.	Time of Death 0:15	
		4a. Facility Name (if not institution, 3107 Goodhope Ave.	give s	treet and nu	umber)		41	c. City, Towr Temple		ocation of D	Death			ounty of D			
Funeral Director		108-40-2535	Sex	1 2 F	7. Age	(In yrs. la:	st birthday) Yrs.	If Under 1 Months		If Under 2 Hours	Min.		nth (MM/DE 5-194		. Birthpi Count	lace (State or Firy) N.J.	oreign
Maryland 28a-f show any d at once.	Director	Usual Residence of Decedent 10a. State 10b. County Md. Prince 10e. Street and Number				Oc. City, T	Town or Location Templ	e Hill 10f.ZipCo	de	0	1	1	0g. Citizer	n of What (1	Od. Inside City L Yes 2	_
death with the or items 23a or must be notifie	by Funeral Di	3109 Goodhope 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 X Divo	ried	Enue Armed F X Yes Yes, Give Yes or Dates:	orces?	No	If Ye	Decedent of s, specify Co	uban, I No	anic Origin? Mexican, Pu specify:	uerto R			White, et		n Indian, 8lack,	
5-0036 Iled within 72 hours after Hygiene I other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Speci Elementary/Secondary (0-12) 12th grade	fy only	highest gra		- (16a. Decedent' during most of w Mili	orking life, E				rk done		d of 8usine	ess/Indu	ıstry	
21215-0036 Uld be filed within 72 h Mental Hygiene marked other than "r r event, the Medical E	Be	17. Father's Name (First, Middle, L Ünkn		D:						Lida		First, Middle,	.a			iels	
Baltimore, MD 21215-00. permit Pages I and 2 should be filed with Department of Health and Montal Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Moc	To	19a. Informant's Name/Relationshi Rasheedah Rahma 20a Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Special Signature of Funeral Service L	an 3 ecify:	Removal fi	augh	Cal	lace of Disposit rematory or othe Verton 22. Na	Holland ion (Name of er place)	Ave of ceme Cem dress o	e. Apt etery,	1F 4-	Bronx, Date 19-06 Balt	NY 104 20c Loc Cal		on,	wn, State N.Y. 21202	
Physician /Medical xaminer		23a Part I. Enter the disease, or or failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	n each	ations that o	aused th	ne death. Otic c	Do not enter the	e mode of dy	ying, s	uch as card						Approximate Int Between Onse Death	
ed sait	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b. Di c.	ue to (or as a	a consec	quence of):										
b0, te be executed ysician and burial - transit	edical I	X unpended	d.	AMENDED	ite	n#1,16 PT	a-b,19b,2	23a,27,	perF	H,Æ,g	855,	5/3/06 '	П				
Box 6876(g death certificate the attending physed for use as the b	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr		23c. If yes, 1 Live 4 Preg 9 Unkr	birth nant at ti		ancy 2 Fet	al death er (Specify)	3 [Ectopic pr	regnan	су		Date of del l onth	ivery Day	y Year	r
S, P.O. B nires that the d n signed by the d be detached		Part II. Other significant condition	ons o			but not re	sulting in the u	nderlying ca	use giv	ven in Part I	l.	1 Ye	s 2f	No 3	Probab	cause of death	nown
Record The law req	Completed by											1 🗸 Yes	psy ormed?	prior deat	to com	osy findings ava expletion of caus	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ation: To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pendi 2 Accident Invest		spital: 1 28a. Date (Mont	Inpatien of Injun h, Day,Ye		ER/Outpatient 28b. Time of In	3 DOA	. Injury	of Death (CI Other 1 N at Work?	Nursing 2			ce 6 🗸 (Other: S	cene	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	4 Homicide deterr	ysicia	(Specify	est of my	knowledg	me, farm, stree	red at the tin	ne, dat	e and place	e, and d	or Town,	State)	manner as	started		City
To the within To the comple	Medical	one) 2 Medical Exam 29b. Signature and title of certifier	á	On the basis and manner		ination ar	nd/or investigati	29c. Li		number	rred at	the time, date	29d. Da		(Month	cause(s)	
1+1		30. Name and address of person of Ana Rubio MD. Ass		mpleted cau			^{23a)} 111 Penn S				1201		Ahiii	. 1, 2000			
		Alia Nubio MD. ASS	ətdili	ivicultal	LAdill	HEI	, i i reilli S	ucet, Dal	uniol	C, IVID Z	1201						

State Registrar

1/1

31 Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

				State of Maryland / D			Mental Hyg	-	1.305
		Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> MELVIN GERALD YOUNG S	SR.		2. Date of Death	h Day Year るし くひひも	3. Time of Death
2		Examir		4a. Facility Name (If not institution, give street and number)		wn, or Location of Deat	h	4c. County of Dea	uth
				UNIVERSITY Speciality Hosp 5. Social Security Number 6. Sex 7. Age (In yrs. last bin		TIMONE TO VICE (ear If Under 24 Hrs	10.0 (0:11	N/A	
		Funeral Director		1218-36-238/		Pays Hours Min.		1939	thplace (State or Foreign quntry) laryland
		yland sow		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
		e Mar le-f st	ctor	Maryland Anne Arundel Brook	:lyn Park				1 ☐ Yes 2 Mo
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic avent, the Medical Example, injust to indiffer a pone.	Funeral Director	10e. Street and Number 5408 Park Road	10f. Zip Co	21225	10	og. Citizen of What C	
		er dea	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
	336	urs aft al', or	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 9 Year or Dates:	1 ☐ Yes 2 🗱	No Specify:		Specify: W	nite
	2-0	72 hou	eted	15. Decedent's Education 16a.	Decedent's Usual O	ccupation	1	l6b. Kind of Business	/Industry
	21	vithin ne.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use n	fone during most of wo etired)	rking	V 1 M . 1	
	d 21	filed w Hygiei ther th	CO	17. Father's Name (First, Middle, Last)	Maciiiii		me (First, Middle, M	Ward Mach	ine
ound	Maryland 21215-0036	ould be i	To Be	Wilbert H. Young		Goldie	e L. Le	hmuth	
10	Mai	d 2 sh th and 17 is n treun				treet and Number or Ru			
_		s 1 an í Heal item 2 other			08 Park R Disposition (Name of			ryland 212	
17	E O	Page:		1 Burial 2 □ Cremation 3 □ Removal from State Glen	v, crematory or otner Haven Mem	Park 04-2	26-06 G	len Burnie	, Maryland
Melvin	Baltimore,	permit. Departmitimporte any injuite.		21. Signature of Fureral Service Licensee M00175 Kevin E. Ecker		1			ryland 21225
		Dhysisian		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of	dying, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
4		Physician / /Medical		disease or condition resulting in death) a	ncopha	LEPATNY			1 month
		Examiner	1-1	Sequentially list conditions, b. Carelia pul ma		rrest—			
		ited	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		comp ctis	0.000		
	ó	execu an and rial-tra		that initiated events resulting in death) Last c. Aheros de Due to (or as a consequence of	1	CH3.	C41 .		
	8760,	cate be executed obysician and the burial-transit	ical						
	9	entific ding p	/Med	IF FEMALE:					
	P.O. Box	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊇ No 9 □ Unknown	3 ☐Ectopic pregna 5 ☐ Other (specify			23d. Date of de Month	ivery Day Year
	ds, P.	uires that signed by Id be deta	þ	Part II. Other significant conditions contributing to death but not resulting in Dichetes mellitus, Chrenic re-	4			acco use contribute to	the cause of death?
	CO	s been si should	lete	Hemoelialysis, Respiratory Jeilure	ventia	tor de parten	∠ 24a. Was an	24b. Were au	itopsy findings available
	Division of Vital Records,	sicien: The law scertificate has t lirector, page 2 s	Completed	Osteonylihs of heals, chmurca	mal Finalle	they.	autopsy perform 1 Tes 2	ed? prior to death?	completion of cause of
	Vit	sicier: certif	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Impatient 2 □ EF/Outs			th (Check only one,		
	of	iding Physicien: th. After this certifical funeral director,	-	27. Manger of Death 28a. Date of Injury 28b. Ti	me of 28c. I	Other: 4 Nursing H	ome 5 ☐ Hesiden 28d. Describe how		cify)
	ion	tending feath. for: Aft the fun	atlo	2 Accident investigation		Work? 1 ☐ Yes 2 ☐ No			
	Divis	al or Atter after de Directo	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	m, street, factory, off	ice	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
		To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medicel Exeminer: On the basis of examination and and manner stated.	death occurred at th /or investigation, in n	e time, date and place ny opinion, death occur	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
		To th within To th compl	Me	29b. Signature and title of certifier	29c. Lic	ense number	290	d. Date signed (Monti	n, Day, Year)
I)	1			D	30494		4122166	
	L	1		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)		2 /		
		* * * * * * * * * * * * * * * * * * * *	ė	**X DESA I mm USH 6 c SOUTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 charles	smeet &	alhmore	m10 x 123	0
		Sta Registra		31. Date filed (Month, Day, Year) APR 2 7 2006 APR 2 7 2006	Specific				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 0scar Arqueta April 14,2006 3:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

Aug. 8, 1974 5. Social Security Number Unk6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M 2□F 30 Yrs El Salvador Director Usuel Residence of Decedent the Maryland **e**how 10a. State unk 10b. County 10c. City, Town or Location 10d. Inside City Limits unk unk ral', or Iteme 23a or 28a-f ehov Examiner must be notified at unk Yes 2 No Director 10e. Street and Number unk 10g. Citizen of What Country? 10f. Zin Code unk unk death 1 Funeral 12. Was Decedent Ever in U.S. unks. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Marital Status unk 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □xes 2 □ No Specify: El Salvador Specify: white þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk al Hygiene. I other than "vent, the Mes College (1-4or 5+) Elementary/Secondary (0-12) unk of Health and Mental Hygis filtem 27 is marked other r other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk unk ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington Adventist Hosp. 7600 Carroll Avenue, Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite any injury or ot once. 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 ②Other (Specify) in state Ronald S. Wade, Director Baltimore, MD 21201

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 655 W. Baltimore St. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner do ea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has l lirector, page 2 s autopsy 1 Yes 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ရ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Oth of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pelli Hospital within 24 hours a
To the Funerel (
completely filled 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier \$ 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Anjum Ghias Qazi,MD, 7610 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State and I Registrar APR 2 8 2006

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2 Deta of Death 3. Time of Death Month Yaar **Physician** 0730 Hdams 26 06 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Nursing Home tredencia trederic If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) Data of Birth (Month, Day, Yaar) **Funeral** Days Months 1□ M 2□ F Vrs 013-12-4159 Director June 11. 1917 New Jersey Usual Rasidanca of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylend Deperminent of Health and Mental Hygiene.
Important: if itan 27 is marked other than "natural", or items 23s or 28s-f show any lollury or other traumatic event, in a Medical Experiment man be notified at 10d. Insida City Limits 10a Stata 10b. Counts 10c. City, Town or Location 1 ☐ Yas 21 No Directo Marvland Howard Elkridge 10f Zip Code 10g. Citizan of What Country? 10e. Street and Number USA 21075 Funerai 6338 Rowanberry Drive 12. Was Dacadant Evar in U,S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. ☐ Yas 2 📆 No f Yas, Giva 1 Navar Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes M☐ No Specify: Specify: ģ 3√Widowed 4 ☐ Divorced Yaar or Datas: White Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retirad) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grede complated) Elamantary/Secondary (0-12) College (1-4or 5+) 8 Clerk Typist Prince George County 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) Be Ida Lander John William Klink 19b. Mailing Address (Streat and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Typa, Print) Kathleen Sweeney- daughter 6338 Rowanberry Drive, Elkridge, MD 21075 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Fort Lincoln Cemtery 5/02/2006 Brentwood, Maryland 21. Signatura of Funeral Salvice Licensaa 22. Nama and Address of Facility
Gary L. Kaufman Funeral Home at MMP, Ma1234 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaen Onsat and Daath **Physician** Immediate Cause (Final disaase or condition resulting in death) Allegical Examiner Examiner ettending physician end for use as the buriel-transit The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or injury that initiated avents rasulting in daath) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consaguanca of): ed by the e 23b. Did tobacco usa contributa to tha causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by should be detect 3 Probably 4 Unknown 1 Yes 2 No ģ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? Completed page 2 s 2DING 1 ☐ Yes 2 ☐ No 1 L Yes Director: After this certificate in by the funeral director, pag or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 2 No Hospital: Othar: P 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Rasidence 6 Other (Spacify) 27. Mannar of Daath . Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accidant 5 Panding invastigation 2 □ No 1 Tas Director: 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the basis of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier within 2 29c. License number 29d. Date signad (Month, Day, Yeer) 29b. Signature and little of certifie ause of death (Itam 23a) (Type, Print) 30. Nama and address of parson who 300

State Registrar

DHMH 16 Rev 6/95

31. Data filad (Month, Day, Year) 32. Registrar's Signatura

ORIGINAL

	1		1- State of Registrar	Maryland /		irtment of tificate of				giene)6	13309
	Physici		1. Decedent's Name (First, Middle, Last) Elizabeth P.	Aston					2. Date of De.		3 Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and numb		10	4b. City, Town,	or Location	of Death	177	4c. Coun		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7.	Age (In yrs. last I	-	If Under 1 Yea Months Days		r 24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)	Co	hplace (State or Foreign
	TO		Usual Residence of Decedent						May 23	3,1913	Wil	Liamsport,PA
	Aarylar f show	ō	MD Harford	10c. City, To	own or Loc Bela							10d. Inside City Limits 1 M Yes 2 □ No
	or 28a-	irect	10e. Street and Number			10f. Zip Code				10g. Citizen of	What Co	
	ath wit	raiD	467 Amelanchier Court			2101				US		
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or Itama 23a or 28a-1 show event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Yes, Give 1 Was Deceded Armed Force 1 Yes, Give 1 Yes, Give 1 Year or Date	es? S≸No	If	Vas Decedent of Yes, specify Cu ☐ Yes 2 1 1 No	ban, Mexica	n, Puerto F	cify Yes or No Rican, etc.)		ack, White	rican Indian, e, etc. Vhite
2-0	72 ho "natur	eted	15. Decedent's Education (Specify only highest grade completed)	16	Sa. Deced	ent's Usual Occu kind of work done OO NOT use retir	upation e during mos	st of workin	g	16b. Kind of I	Business/	Industry
2121	d within piene. r than	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)		memaker	ed)			Own Ho	ome	
	m = 0 5	Be	17. Father's Name (First, Middle, Last) Edwin Arthur Pyles							Maiden Suma		
Maryland	should be of marked or marked or	ျှ	19a. Informant's Name/Relationship (Type, Print)	15	9b. Mailine	g Address (Stree				vania N		
	and 2		Barbara Aston / Daughter		467	Amelano						
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Itam 27 is marked any Injury or other traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from Sta 1 ☐ Donation 5 ☐ Other (Specify)	te cemer	tery, crem	sition (Name of atory or other pla Cremator		April 2006	26,	20c. Location Baltin		
Ba	permit Depart Impor any In		21. Signat (Fe of Funeral Service Licensee			Name and Addr Charles I 1501 Fast	Steve	ens Fur	eral Ho	me Inc.		
8760,	Physician and // Medical burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence	ce of):	or the mode of dy	ing, such as	s cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	Physician/Med		2 Fetal death		Ectopic pregnand Other (specify)	су				ate of deli	very Day Year
	res that igned b be deta	by	Part II. Other significant conditions contributing to deat	but not resulting	g in the un	derlying cause gi	iven in Part I	l.		/		the cause of death?
Sorc	w require been sign should b	Completed	Penohima Va	1 ember	du	a ade			1	es 2 No		obably 4 Unknown topsy findings available
Division of Vital Records,	hysician: The law his certificate has t I director, page 2 s	Somp	· · · · · · · · · · · · · · · · · · ·		000				autop		prior to c death?	ompletion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?			0.			(Check only o	ne)		
O	g Physical dispersal di	n: To	27. Manner of Death 28a. Date of I		Outpatient Time of Injury	3□ DOA 28c. Inju	4 (34) 14(lence 6 Otl		ıfy)
SIO	tendin death. tor: Af the fur	catlo	2 Accident investigation			M 1	Yes 2					
2	al or A	Certification:	determined 286. Place of	Injury - At home, etc. (Specify)	ram, stre	et, factory, office		28	City or Tow	n, State)	ber or Ru.	ral Route Number,
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funerel Director: After this certifica	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besidence only one) 1 Medical Examiner: On the basiand manner	s of examination a	ge, death and/or inve	occurred at the t estigation, in my	ime, date ar opinion, dea	nd place, ar ath occurred	nd due to the o	ause(s) and m	anner as and due	stated. to the cause(s)
	To T To I	Σ	29b. Signature and title of certifier				se number 26 0	9		29d. Date signe		, Day, Year)
ı	7		100	of death (Item 23a	i) (Type, P							
l	*		Kamrudy Miliam M 31. Date filed (Month, Day, Year) 32.	1100 Ren	ralut	ion st.	Mo	wre	De G	roue,	n) 2	1078
	Sta Registr		30. Name and address of person who completed cause of Samrudy Milyan. M3 31. Date filed (Month, Day, Year) APR 2 8 2006	was de	Ale	and I	,					

			1 - For Stete Registrar	State of M	aryland / Dep Ce		t of Health			ene	6 13310	
	Physici		1. Decedent's Name (First, Middle, Last Katherine Vera						2. Date of Death Month	Day Y	3. Time of Death	
	/Medi Examir		4a. Facility Name (If not institution, give Gilchrist Hosp	street and number)		4b. City,	Town, or Locatio		4/25	4c. County of	5:00å Death Baltimore	
	Funeral Director		219 20 0900	x 7. Ag	ge (In yrs. last birthda 80 Yrs.	y) If Under Months		er 24 Hrs. Min.	8. Date of Birth (Month, Day, 11/6/	Year) 9	Birthplace (State or Foreign Country) MD	
	ehow	'n	Usual Residence of Decedent 10a. State 10b. County MD N/A		10c. City, Town or		ltimor	- Cit			10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
8/2	death with the Maryland rme 23a or 28e-f ehow r must be notified at	Direct	10e. Street and Number 1527 Hanover S	treet		10f. Zip				10g. Citizen of What Country?		
) 25,920 JE	rs atter death with the Maryia ", or iteme 23a or 28e-f ehov tarningt must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Armed Forces? 1 Yes 2 121 If Yes, Give Year or Dates:	Ever in U.S. 13		es, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc. Specify: white	
21215-0036	be filed within 72 hour laid Hygiene. d other then "naturel event, the Medical E.	Be Completed t	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5	16a. Dec (Giv	e kind of wor DO NOT us	Usual Occupation of work done during most of working OT use retired) 16b. Kind of Business/Industry					
Actor Vland 2	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, Italia	To Be Co	Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufact									
Afterine Actimore, Maryland	ss 1 end 2 should of Heelth and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Ty Marion Haspert		er 152	5 S.	Hanove	r Str	eet, Ba		re MD 21230	
altimor	Peger ent o nt: tf		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21 Signal Transit Funeral Service License		20b. Place of Disp cemetery, cro Cedar I	matory or of	ther place)	04/	28/2000	oc. Location - Cit 5 Balti	moro MD	
Ba	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused ne cause on each lin	the death. Do not er						eral Home In more MD2123 Approximate Interval Between Onset and Death Gentler	
8760,	Medical Examine bhysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):							
.O. Box 6	The law requires that the death certific to the been signed by the ettending proage 2 should be detached for use as it	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pre □ Other (spe				23d. Date of Month	f delivery Day Year	
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying ca	use grven in Part	11.			te to the cause of death? Probably 4 □Unknown	
al Reco		Completed							24a. Was an autopsy performe	prior deat	e autopsy findings available r to completion of cause of th? Yes 2 \(\square\$ No	
Division of Vital Records, P.O.	ng Phye fter this ineral dir	ation; To Be	27. Manner of Death 1) Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatie 28a. Date of Injur (Month, Day			1 04	lursing Hom	Check only one e 5 Resident dd. Describe how		Specify) MOSPIU	
Divis	2 # 2 E	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, st c. (Specify)	reet, factory,	office	28	Bl. Location (Stre City or Town,	et and Number o State)	or Rural Route Number,	
	To the Hospitei within 24 hours e To the Funerei I completely filled	edical	29a. Certifier (Chack unity one) 2 Medical Examination	ician: To the best of ler. On the basis of and manner sta	of my knowledge, dea examination and/or in ited.	th occurred a	t the time, date a in my opinion, de	ind place, ar	nd due to the cau d at the time, date	se(s) and manne a and place, and	r as stated. due to the cause(s)	
	To the To the Complet		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day APRIL 25 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMAIN CHARLES, WO 6601 N. Charles St. Barrowse WO 212024									
_/	0		30. Name and address of person who co	0 6601 1	V. Charles	Print)	BARM	ore u	1212 an	04		
	Sta Registr		31. Date filed (Month; Day, Year)		tr's Signature	hade	7					

			For State Registrar	State of M	arylan	-	rtment tificate			nd Me		giene () ()	6	13311
	Physici	2.0	Decedent's Name (First, Middle, Last)	4 '						2	2. Date of Dea Month		Year	3. Time of Death
	Physici: /Medic		Victoria V.	Aires							04	26	2006	0814 M
	Examin	er	4a. Facility Name (If not institution, give: Bayview Huspital	street and number)			46. City, To			f Death		4c. County o		- City
	Franci		5. Social Security Number 6. Sen	7. Ag	je (In yrs.	last birthday)	If Under 1	Year	If Under 2		B. Date of Birth			lace (State or Foreign
	Funeral Director		215-03.4368 15	M 201 F	86	Yrs.	Months I	Days	Hours	Min.	(Month, Day		Ma	ryland
	D .		Usual Residence of Decedent 10a, State 10b, County		100 Cib	y, Town or Lo	ention							0d. Inside City Limits
	lanyla ehon	5					Cation							1X Yes 2 □ No
	the h	rect	faryland		ват	timore	10f. Zip C	ode				10g. Citizen of W	hat Coun	dry?
	Marth 13a or	i D	505 S. Tolna Stree	t			212	224				U.S.A.		
	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow dical Examiner must be notified at	Funeral Directo	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	.S. 13. \	Vas Deceder Yes, specify	nt of His	spanic Orig	in? (Spec	ify Yes or No-		- America	an Indian,
36	or Ita	y Fu	1 Never Married 2 Married	1 □ Yes 2 X 1 If Yes, Give	No		Yes 2X		Specify:		,,	Specify:		ite
ö	hours tural	ed by	3X Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:		16a Decer	lent's Usual (Оссира	tion			16b. Kind of Bus	siness/Inc	dustry
15	n "na	piet	(Specify only highest grad	e completed)	E.\	(Give	kind of work OO NOT use	done di	uring most	of working	,	TOD. KING OF BUS	11100321110	lustry
212	e filed within all Hygiene.	Completed	Elementary/Secondary (0-12) 12th	College (1-4or	3+)	Waitr	ess					Restaur	ant	
Maryland 21215-0036	be file tel Hy d oth	Be (17. Father's Name (First, Middle, Last)									Maiden Sumame))	
yla	Meni	2	Gabriel Banks			1					ligan			-11-
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Ty			1						r, City or Town, S		Code)
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentel Hygiene. Inportent: If Item 27 is merked other than "natural; or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at Once.		Mary (Vicki) Irwi 20a. Method of Disposition	n/Daughte	20b. P	lace of Dispo	sition (Name	of		Da Da	gewood,	20c. Location - C	041 City or To	wn, State
altimore,	Pages ent of nt: If I		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		emetery, cren	-		1	4-29-	06	Baltim		MD
altii	mit. I pertm sorte / Inju		21. Signature of Funeral Service Licens	90	SE	. Stan	. Name and	Address	s of Facility	har1	es Zeil	ler & Son	n. II	nc.
Ö	Depermine Depermine Impo		Jessey Nox	7								Baltimo		
Г			23a. Part1 Enter the disease, or compleshood, or heart failure. List only of	alions that cause acause on each l	d the death ine.	h. Do not ent	er the mode	of dying	, such as c	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Sevs	is									Oriset and Death
	/Medical Examiner		resulting in dealth)	Due to (or as	a conseq	uence of):	,							
		er	Sequentially list conditions,	Due to lor as	a conseq	uence of:	ua	-						
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										- 1	
o,	e exec ien an urial-tr	Exa	resulting in death) Last	Due to (or as	a conseq	uence of):								
8760,	death certificate be executed e ettending physicien and ad for use as the burial-transit	Physician/Medicai		1										
9	sath certific ettending p for use as	/Me	IF FEMALE:	3c. If yes, outcome	of pregna	ancv						23d. Date	of doling	
Вох	etten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3□	Ectopic pred Other (spec					Mon		Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown										
	igned be del	by P	Part II. Other significant conditions con	ntributing to death t	out not res	ulting in the u	nderlying cau	ise give	n in Part I.		23e. Did to	1		ne cause of death?
ord	v requires been sign should be										1 🗆 Y	es 2 No	3 Proba	ably 4 Unknown
Vital Records,	aw 2 s L	Completed									24a. Was autop perfor	sv pr	Vere autop rior to con eath?	psy findings available impletion of cause of
a	Tage at										1□ Yes	229 No 11		2X No
Ξ	Physicien: T this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: Inpati	ent 2 🗆	ER/Outpatien	t 3 DOA	Othe			Check only o	ne) lence 6 ⊟Othe	e (Specifi	
10		n; To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of Injury		c. Injury Work				now injury occurre		7
ior	Attending r death. Sctor: After by the funer	atio	1 Natural 5 Pending investigation	(moran, De	y roar,	Підагу	М		'es 2 □ N	No				
Division	or Atten after deat Director: in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e			eet, factory,	office		28	Sf. Location (S City or Tow	Street and Numbe vn, State)	r or Rurai	I Route Number,
	o the Hospitel or At ithin 24 hours after o the Funerel Direct		29a. Certifier 1 Certifying Phy	pician: To the heet	of my kno	wieden death	a accurred at	the time	o date and	d place, as	ad due to the	aguso(a) and mad	2005 20 01	Intod
	24 hc 24 hc Fun etely	edicai	(Check only 2 Medical Exami	ner: On the basis of and manner st	of examina	ition and/or in	vestigation, in	n my op	inion, deat	h occurred	d at the time,	date and place, a	nd due to	the cause(s)
	within 2	Me	29b. Signature and title of certifier				29c. I	License	number			29d. Date signed	(Month, I	Day, Year)
	7		Helalu	Smill	10	an		2	201	07		4/2	261	106
1	0		30. Name and address of person who co	empleted cause of	death (Iten	п 23а) (Туре,	Print)	1		100	re,	100	7	22/1
	ν • • • • • • • • • • • • • • • • • • •		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	levu	e 1.	50	iti	MA	re,	nes)	$\propto 1$	L2T
	Sta Registi		APR 2 8	1 . 5'5	GARA S	All A	formis !	•						

			For State Registrar	State of M	laryland		artmen rtificat			and M	lental F	łygie Reg.	Car for 1	16	13312
1	ni.		Decedent's Name (First, Middle,		<i>a</i>						2. Date of Month		Day	Year	3. Time of Death
	Physicia /Medic		LEO	W. BEALL	SR.						April	23,		2006_	8:45 p ^M
,	Examin	er	4a. Facility Name (If not institution, g						Location of	of Death			4c. County		
77.	· 法 · . 第1	× .	Millennium Hea		itation ge (In yrs. Ia		G1 If Under	en Bu	rnie If Under	24 Hrs.	8. Date of	Birth	_Anne	Arund	
	Funeral Director	61	215-05-8773	1 M 2 □ F	92	Yrs.	Months	Days	Hours	Min.	Jan.	Day, Ye	ar) Q1/ı		place (State or Foreign ntry) vland
40	ill ector	e i	Usual Residence of Decedent) <u>L</u>						Jan.	10, 1	714		
rylan	how		10a. State 10b. County		10c. City	, Town or Lo	ocation								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
e Ma	Sa-1 s	cto	Maryland Anne A	rundel	Pa	sadena									
death with the Maryland	or 2	Funeral Director	10e. Street and Number				10f. Zip	Code	0110			10g.	Citizen of		ntry?
athw	or Iteme 23a	ral	8399 Forest Drive		A Ever in 11.5	* 12	Was Dasse	dant of Li	21122		noity Vac or	No	U.S.		can Indian,
er de	ltem Der n	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces d 1 Tyes 2	?				n, Mexicar	n, Puerto	ecify Yes or Rican, etc.)	NO.		ck, White,	
UUSO hours ef	l. or	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 No	Specify:				Specif	y: Wh	nite
within 72 hours efter	nal rygiene. id other than "natural", or lieme 23e or 28e-f show event, tre Medical Examiner must be notified at	ted	15. Decedent's	Education		16a. Dece	dent's Usua	al Occupa	ation	t of work	ina	16t	. Kind of B	usiness/In	ndustry
Find 7	Med	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wo DO NOT u	se retired,)	CO WOTA	9				
filled wi	ver th	Completed	3	0		Wel	ldrer		40 14 11	1. 1.	- (Files a 44)		esting		Corp.
d be fi	od oth	Be	17. Father's Name (First, Middle, La Elisha N.	Beall						ers Name ery	e (First, Mid C. (oie, maii Dutsa		ne)	
should	Health and Mental Hyglene. tem 27 is marked other than other traumatic event, trains	ဥ	19a. Informant's Name/Relationship			10b Maili	na Address	(Stroot a			al Route Nu			State 7ii	n Code)
d 2 st	7 Is n traun		Leo W. Beall Jr.	(Son)			•	•			ia, Mari		-	, 31816, 27	o code/
a	item 2 other		20a. Method of Disposition	(5011)	20b. Pl	ace of Dispo	osition (Nar	ne of			Date		Location	- City or T	own, State
ages	t: Hit		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Α	n) Haver	-			04-26	-05	GL	en Bur	nie. M	aryland
Saltimor	partment of sortaint: If it it it it it it it it it it it it it		21. Signature of Funerfal Service Li	-	1.										
Darg permit.			Jano St	Danne	U]	1	McCully	y-Poly	miak l	Funera	3204 l al Home	P.A.	Maryl	and 21	1122
			23a. Part1. Enter the disease, or concern failure. List of	omplications that cause	ed the death	. Do not en	ter the mod	le of dying	g, such as	cardiac	or respirator	y arrest,			Approximate Interval Between
Ph	ysician		Infimediate Cause (Final disease or condition		audio	ac	Am	1/to	ma						Onset and Death
/N	/ledical		resulting in death)	Due to (or a	is a consequ	ience of):									
Ex	aminer		Sequentially list conditions.	b											
/ p	şit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequ	ience of):									
be executed	and I-tran	хап	that initiated events resulting in death) Last	c Due to (or a	ıs a consequ	uence of):									
/oU,	hysiclen and the burial-transit	caiE	1												
death certificate	phy:			d			-								
BOX eath cert	ettending phy for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1□Live birth			⊒Ectopic p							ate of deliv	
	e ette	sicia	in the past 12 months? 1 ☐ Yes 2 X No	4 Pregnant			Other (sc					_	M	onth	Day Year
j g	by the e	Physician/Med	9 Unknown												
Kecords, P.O. The law requires that the	igned b	b	Part II. Other significant condition	s contributing to death	but not resu	Ilting in the u	anderlying o	ausa give	en in Part I	l. 2_			co use con 2 🗆 No	3 ☐ Pro	the cause of death? bably 4 Unknown
ecord law requir	been si should	ted	Count	Correct	are	(00	7	03	e u			-			
e e	asb e2st	Completed									24a. V	Vas an utopsy erformed		Were auto prior to co death?	opsy findings available empletion of cause of
	s certificate has blirector, page 2 s	ပိ									1 🗆 Ye			1 Yes	2 No
Vital sician:	sertifi	Be	25. Was case referred to medical examiner?	Hospital:				Othe	- /		h (Check or				
_ >	97 0	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpar		ER/Outpatie 28b. Time of		JA	4 (30N)	ursing Ho	ome 5 F				(fy)
on ging	After fune	tion	1 Natural 5 Pending 2 Accident investiga	(Month, D	Say Year)	Injury	М	28c. Injury Work 1 🔲 '	k? Yes 2□	No					
DIVISION I or Attending	dear octor	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of I	njury - At ho	me, farm, st	reet, factor	y, office						ber or Rur	al Route Number,
	d in t	Certification:	4 Homicide	building, i	etc."(<i>Specif</i> y	7)					City or	Town, S	iaie)		
DIV To the Hospital or	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral			Physician: To the bes											
the H	the F	Medicai	one)	and manner											, Day, Year)
٩	To	2	29b. Signature and title of certifier				29	C. License	e number	500	\circ	∠90.	✓ 1 1	(MORIE)	1 \ \
	~					00 : 0		U) () SK	5_		U4	1d	1100
	8		30. Name and address of person w	no completed cause of	r death (Item)	1 23a) (Type	THI)	21	an	mail	Mi.	< V	2) =	INLI
100 mm	State Sta	ate	31. Date filed (Month, Day, Year)	32. Regig	strar's Signal	ture	TI OK	<u> </u>	131		MI	ار	1 11		
	Regist		200 9	9 2000	,	20	Local	8							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland		artment of F rtificate of		Mental Hygie	La U U U	13313
, \$4 ₁	Physicia		Decedent's Name (First, Middle, Last George	E. Berkeridg	e Sr.	•		2. Date of Death Apticular 2	Day Year 7 2006	3. Time of Death 12:17а м
	/Medic Examin		4a. Facility Name (If not institution, give Gilchrist Cen			4b. City, Town, o			4c. County of Death Baltimo	
	Funeral Director		212 30 3333	ex RM 2□F 7. Age (In yrs. Ia 73	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. 8. Date of Birth (Month, Day, Y Sept. 16	9. Birth , 1932 Mar	place (State or Foreigr ntm) Yland
	f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Bal		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
;	3a or 28a	i Director	10e. Street and Number 1618 Howard A	ve.		10f. Zip Code 212:	21		. Citizen of What Cou SA	intry?
	c should be filed within 72 hours after death with the maryland and Mental Hygiene. and Mental Hygiene. It is marked other than "natural", or items 23s or 28s-f show aurmatic svant, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? U∑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2XNo	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
200	a within 72 ho jiene. r than "natur It e Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 8th	ide completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire K Drive:	during most of w	vorking	b. Kind of Business/li uinn Fre	ight Line
ylalid	Mental Hyg Mental Hyg arked othe atic svant,	To Be C	17. Father's Name (First, Middle, Last, George S. Berk				Mary 1	ame (First, Middle, Ma Ellen Sen	sabaugh	
, Wal	27 = 27 = 27 = 27 = 27 = 27 = 27 = 27 =		19a. Informant's Name/Relationship (Helen Berkeric	lge /wife	161	8 Howar	and Number or d Ave.	Rural Route Number, C Baltimor	e MD	
	permit. Pages 1 av Department of Hea important: if item any injury or oths		20a. Method of Disposition ★□ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State Me	a'dow	osition (Name of major or other pla		29/06 B	c. Location - City or 1 altimore	MD
Da	permit. Departitimport		21. Signature of Funeral Service Licer	1 (annul	Ly C	onnelly	Funer	300 Mace al Home o	f Essex	to. MD 21221
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	deations that caused the death che cause on each line. a	1272	ter the mode of dyn			t,	Approximate Interval Between Onset and Death CORRELATION
Ĺ	icate be executed with physicien and physicien and strengt strengt with purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)						Weeks
O. BOX 001	death certif e attending ed for use es	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[⊒Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliment	very Day Year
ds, F	as tha	5	Part II. Other significant conditions	contributing to death but not resu	lting in the u	underlying cause gr	ven in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	
Lec	The law ate has b page 2 s	Completed						24a. Was an autopsy performe	prior to o death?	topsy findings available ompletion of cause of
N Ta	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	H				Death (Check only one)		-1/
5	Physi this c	2	1 ☐ Yes 2 ♠ No 27. Manner of Death		28b. Time o	III SLI DOA		Home 5 Residen		HOSPIC
DIVISION	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeret Director: After this certification of the funeral director, the funeral director director director, the function director di	Certification;	1 Statural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	M 1	ork?]Yes 2 No		et and Number or Ru	ral Route Number.
2	spital or A ours efter neref Dirs filled in b		4 ☐ Homicide determined	building, etc. (Specify)			City or Town,		stated.
	o ths Hos vithin 24 h o ths Fur completely	Medical	(Check only 2 Medical Exa	miner: On the basis of examinat and manner stated.	ion and/or in	nvestigation, in my	opinion, death o	ocurred at the time, dat	e and place, and due	to the cause(s)
			30. Name and address of person who	completed cause of death (Item	23a) (Typa	Print)	5 205	19	toril2	7,2006
) Sta	ate	31. Date filed (Month, Day, Year)	SZ legistrar s Digital	76 ture	N.Chr	ila It	polts.	WW 212	ed je

DHMH 17 Rev 1/2001

		,	FOR	eartment of Health and Mertificate of Death	ental Hygien	4 U U O	13314
<u> </u>			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Kathleen M. Brashears		April 2	²⁴ , 2ðð ¹ 6	11:30 ам
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
*			10990 Horseshoe Drive	Frederick		Frederi	
	Funeral		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	r) Cou	place (State or Foreign intry)
Mg (S	Director		0 6 8 - 3 8 - 9 1 2 9 58 Usual Residence of Decedent		06/21/19	47	MD
	land ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Many First	ţō	MD Frederick Freder:	ick			1 ☐ Yes 2 📉 No
	7 28 1 1 28	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Cou	intry?
	death with the Maryland ms 23a or 28e-f show r must be notified at	aiD	10990 Horseshoe Drive	21701		USA	
		Funeral	Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
20	72 hours after natural', or its alcal Exemins	by Fu	1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify:	
2-003p	hours lural			edent's Usual Occupation	16h	Wh Kind of Business/Ir	ite
	n 72	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work! DO NOT use retired)	ng 166.	Mild of pasitiessyll	idustry
717	within lene. then	mo du	Elementary/Secondary (0-12) College (1-4or 5+) 2 A d r	ninistrative Sec	retary	Relig	ion
	other	a l	17. Father's Name (First, Middle, Last)		(First, Middle, Maide		1011
	uid be Mental rked c	To B	Donald P. Playne	Alberta	V. Chil	d	
	ges 1 and 2 should be filed t of Health and Mental Hyg If Item 27 Is marked othe or other treumatic event.			ling Address (Street and Number or Rura			p Code)
Ξ	permit. Pages 1 and 2 Department of Health Importent: If Item 27 II any injury or other tre		John F. Brashears Husband 1099	00 Horseshoe Dri	ve Frede	rick MD	21701
o c	of He of He fiten		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of permatory or other place)	ate 20c.	Location - City or T	own, State
Ě	Pag ment ent: I ury o		4 □Donation 5 □Other (Specify) Mount	01ivet 4/28	/2006 Fr	ederick	. MD
saitimore,	permit. Departimport Import any inj			22. Name and Address of Facility K e e	ney and	Basford	P.A. F.H.
ш	20 E 2 G			.06 East Church		rederic	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac of	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a Non Hodg Kin)	lymphones			5 m.
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	0 1			
	LAUTHITCI	_	Sequentially list conditions, b.				
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and and II-trar	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
3/60	ate be executed hysicien and the burial-transit	dical E					
200		edic	U				
XOX	death certific e attending pl d for use as I	ician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	-		23d. Date of deliv	төгу
ň	death a atte d for	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
9	t the by the	Physi	9 □ Unknown				
ω, J	The law requires that the de ste has been signed by the a page 2 should be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		100	the cause of death?
ä	w require been sig should b	ed	CYSTIC FIBROSIA		1 🗆 Yes	2MNo 3∏Pro	bably 4 🗀 Unknown
၁၁	e taw re has be je 2 sho	ple			24a. Was an autopsy	24b. Were aut	opsy findings available empletion of cause of
Ï		Completed			performed? 1 ☐ Yes 2 🗷 N	death? No 1 ☐ Yes	
Vital Records,	Hospital or Attending Physicien: The it 24 hours after death. Funerel Director: Alter this certificate ha tely filled in by the tuneral director, page ?	Be (25. Was case referred to medical examiner?	26. Place of Death			
<u>></u>	Physic this coral dire	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		ne 5 Residence		fy)
Division of	ding P h. After t funera	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how in	jury occurred	,
Sio	r Attendi ter death. frector: A r by the fu	cat	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury. At home farm	M 1 Yes 2 No	28f. Location (Street	and Number of Co.	- / Paula N ba
<u> </u>	after d Direc Jin by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	City or Town, Sta		ar Houte Number,
_	spital or ours afte nerel Dir filled in		29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, de:	ath occurred at the time, date and place	and due to the cause	(c) and manner as	stated
	No Hospital	edical	(Check only 2 Medical Examiner: On the basis of examination and/or one)				
	within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month	Day, Year)
•	/) All (MI)	D 48184	4	124106	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)	T 1.	(/ , 12)	017.1
)	2000		Elhamy Eskander, MD 501	D 48184 Print) W Th Street	trederica	5 MD	2110
		ate	31. Date filed (Month Pay Year) 8 2006 32. registrar's Signature	beele			
- 3	Regist	rar	THE A COOL TO SALES				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 21, 2006 **Medical Examiner** 1510 hrs Braithwaite 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2728 Maryland Ave Baltimore N/A 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Months Hours Davs Director 219-76-5939 $_{1}X_{M}$ 12/11/1959 46 Country) 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A Baltimore 28a-f shov leath with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2728 Maryland Avenue 21218 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc Yes or i 1 Yes 2 X No specify: White Widowed Divorced f Yes. Give Year Specify "natural" 16a. Decedent's Usual Occupation (Give kind of work done Pages I and 2 should be filed within 72 hours nent of Health and Mental Hygiene aut: If item 27 is marked other than "natur or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Custodian Church 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Beverlev Braithwaite Rozella Wm. Ann Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Morgan - sister 1707 Langley Road, Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 4/26/2006 Beltsville, MD Donation 5 Other Specify MO0986 CAFA, Stephen D. Lohrmann, 8717 Green Pastures Drive, 21. Signature of Funeral Service Licensee Towson. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Atherosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED item#23a,PII,27,perME,g855,5/1/06 TT AMENDED ending physician use as the burial that the death certificate be Box 68760, 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death Dav Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions o. 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I ρ Records, P. Yes 2 V No 3 Probably 4 Unknown Chronic drug use Completed 24a. Was an certificate has been 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 V No 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Division of Vital Be Other₄ 1 Inpatient 2 DOA Nursing Home 5 Residence 6 Other Scene After this 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred Manner of Death 28b Time of Injury 28c. Injury at Work? Certification: 1 X Natural Pending 1 Yes 2 No 24 hours after death Funeral Director: the Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. within 2. To the F 2, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 22, 2006 of pers who impleted cause of death (Item 23a) 30. Name and addri Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) Registrar

ORIGINAL

			State Registrar		epartment of Health and M Certificate of Death	Reg. No.	
	Physicia		1. Decedent's Name (First, Middle, Last)	Be	EEKS	2. Date of Death Month Day APRIL 20	Year 3:15 AM
	/Medic Examin		4a. Facility Name (If not institution, give s HARBOR HC	SPITAL	4b. City, Town, or Location of Death BALTI Mo	RE 4c.	County of Death
	Funeral Director		5. Social Security Number 6. Sex 2 18-44-3697 1	M 204F 7. Age (In yrs. last birthe	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) 1945 Maryland
:1215-0036 within 72 hours after death with the Maryland	a or 28e-f ehow be notified at	Funeral Director	10a. State Maryland 10b. County A 10e. Street and Number	10c. City, Town of Bro	or Location OKIVI 10f. Zip Code	10g. Citi	10d. Inside City Limits 1 □ Yes 2 □ No izen of What Country?
0036 ours after death	Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "netural", or items 23a or 28e-f ehow important: If Item 27 Ie marked other then "netural", or items 23a or 28e-f ehow eny Injury or other traumatic event, the Madical Exercitor roast be notified at 00ce.	۾	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-003	ygiene. ser then "netu t, the Madica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired) AS NEW 118 Methods New	ing	Vernment Agency
ryland	d Mental H marked off matic even	To Be	17. Father's Name (First, Middle, Last) LVQ 19a. Informani's Name/Relationship (Type)	McDuffie	Mailing Address (Street and Number or Rur	le Ale	xander
Baltimore, Ma	t: If Item 27 le		20a. Method of Disposition 1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify)	CYWD DO 95	39 Jack St.	Brook	ocation - City or Town, State
Baltir	Departme Importan eny Injur		21. Signature of Funeral Service License	L. Russ	22. Name and Ad ress of Facility Joseph L. Russ 2222 W. North	Funeral	theme P.A.
	hysician /Medical		23a. Part/ Enter the disease, or complishoty, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ie cause on each line.	ot enter the mode of dying, such as cardiac ENCEPHALOPA (1):		Approximate Interval Between Onset and Death
8760,	ysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	,		4 WEENS
Box 6	e attending p	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2□ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
<u>و</u> ۵	w requires inates been signed by should be detailed		Part II. Other significant conditions cor	itributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
of Vital Records, P.O		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vita	ysicien: III is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes ZANO	lospital: 1 Inpatient 2 ER/Out	Other	Ih Check only one ome 5 ☐ Residence	6 □Other (Specify)
	er er er		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Ti	ime of 28c. Injury at work? M 1 Yes 2 No	28d. Describe how inju	ny occurred
Division	i o the hospital of Attends within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
	24 hou 24 hou Funer etely fill	edical	29a. Certifier 2 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and place t/or investigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
,	within To the compl	Me	29b. Signature and title of certifier	INTERN	29c. License number RES OO\	1	ate signed (Month, Day, Year) RIL, 20, 2006
2	\			3001 South HAN	Type, Print) JOVER STREET, BAL	TIMORE, M	MARYLAND 21225
燕	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 8	32. Registrar's Signalure	Souli		
DHM	IH 17 Rev 1/2	2001	-	OF	RIGINAL		

Boyer, MARGANET

1331

		-	For State Registrar		,	Certificate of	of Death	R	eg. No.	Ub	1331
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day	Year	3. Time of Death
	hysicia /Medic		Margaret S. Boye	er				April	25	2006	02:50 AM
	xamin		4a. Facility Name (If not institution, give			4b. City, Tow	m, or Location of De	ath		y of Death	
			Baltimore Washingto		il (enter				Arne		
	neral ector	- 1	220-20-1855	7. Ag	e (In yrs. last birt 78	hday) If Under 1 Y Months Da	ear If Under 24 H ays Hours Mi		, Year)	9. Birthp Cour Maryl	oface (State or Foreigntry) and
pur	226	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	IOd. fnside City Limits
hours after death with the Maryland	D TO	ō	Maryland Anne Arur	ndo1	Glen B	urnie					1 ☐ Yes 2 🛣 No
9 6	989	Directo	Maryland Anne Arur 10e. Street and Number	idei	Gren b	10f. Zip Cod	de	1	l 0g. Citizen of	What Cour	ntry?
	1					21061			USA		
	2 2	Funerai	1204 Kimberly Lane	12. Was Decedent	Ever in U.S.	13. Was Decedent	of Hispanic Origin?	(Specify Yes or No-	14. Ra	ce - Americ	
	rthen "natural, of tems 23a of 266-1 enow the Medical Examinar must be publified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	If Yes, specify of	Cuban, Mexican, Pu No Specify:	erto Hican, etc.)	Speci	ack, White, ify: Whi	
/2 ho	atur Cal		15. Decedent's Edu	cation	16a.	Decedent's Usual O	ccupation	unrting	16b. Kind of I		
ene.	Med	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use re		VOIKING			
		E C	12			a Process	ing Süper	visor S	Super E	resh	
tal Hygi	o othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Suma	me)	
Mental		To	Calvin B. Smith				Marga:	ret Framp	ton		
9	ᄩᄩ		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b.	Mailing Address (St	reet and Number or	Rural Route Numbe	r, City or Town	n, State, Zip	Code)
of Health a	n 27 ertr	1	Mary Rattell- daugh	nter				en Burnie			
	if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	lemoval from State		Disposition (Name of y, crematory or other		Date	20c. Location	- City or To	own, State
nent	ant: I		4 Donation 5 Other (Specify)		Metro	Crematory	4/2	5/2006 (Catons	⁄ille,	Maryland
Department	importent: any injury o once.		21. Signature of Funeral Service Licens	00		Gary L. 7250 Wa	ddress of Facility Kaufman Shington	Funeral Ho Blvd., Ell	ome at kridje,	MMP,I	INC. 21075
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only o	ications that cause	the death. Do r	not enter the mode of	dying, such as card	liac or respiratory ari	rest,		Approximate Interval Between
hvs	ician		fmmediate Cause (Final disease or condition	Lun							Onset and Death
	dical		resulting in death)	a	a consequence						
ar	niner										
		Je.	Sequentially fist conditions, if any, leading to immediate	Due to (or as	a consequence	of):					
	ransi	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	C							
	physicien and the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):					
	ysici ne bu	Medical		d						-	
	ing ph e as th	Aed	IF FEMALE:								
	or us	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐Ectopic pregr 5 ☐ Other (specif				ate of deliver	ery Day Year
:	signed by the a be detached t	F.	Part II. Other significant conditions co	atributing to doath h	out not reculting in	the underhing cause	o arren in Part I	23e Did to	nhacco use co	ntribute to t	he cause of death?
	eigne be d	þ	Part II. Other significant conditions co	nunbuning to death t	at not resulting ii	i the underlying caus	e given in raici.				bably 4 □Unknow
	been si should	ted						-			
	2 8	Completed						24a. Was autop	an 24b	prior to co	opsy findings availab empletion of cause of
	page	Con							med?	death?	2□ No
	certificete rector, paç	Be	25. Was case referred to medical examiner?					Death (Check only or	ne)		
	this call dire	္ရ	1 ☐ Yes 2 XNo	Hospital: 1 XInpati		tpatient 3 DOA		g Home 5 ☐ Resid			fy)
מ	After t funera	 0	27. Manner of Death 1 Natural 5 □ Pending	28a. Oate of Inju (Month, Da	ury 28b. f		Injury at Work?	28d. Describe h	low infury occi	ırred	
	or: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No	224			10
s after d	al Director: ad in by the	Certification;	4 Homicide determined	28e. Place of fr building, e	jury - At home, fa tc. <i>(Specify)</i>	rm, street, factory, of	fice	28f. Location (S	street and Nun vn, State)	nber or Hur	al Route Number,
To the Hospital of A within 24 hours after	To the Funerel Director: After this certificete he completely filled in by the funeral director, page	Medicai (of examination an			ace, and due to the occurred at the time,			
o th	ro th	Me	29b. Signature and title of certifier				cense number		29d. Date sign		
- 5		İ	I tem Ina	$\sim m$			627415	Medical	Anil 2	5, 20	<i>ک</i> ا در
	Y		30. Name and address of person who co	ompleted cause of	death_(ftem 23a)	(Type, Print)					
				is M.D.	BAIT	more Wi	Ashinitan	Medical	(tent	1	
		1	1 1 1 1 1 1	17 1							

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment ertificate					giene Reg. No.	06	13318
	- DI		1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Mary Berthold							04	24	2006	7:20 a M
	Examin	er	4a. Facility Name (If not institution, give	e street and number,)	4b. City, 1	Fown, or	Location of	of Death		4c. Co	ounty of Death	ı
			Rosemanor Assist					City				oward	
	Funeral		5. Social Security Number 6. S 340-05-7086	00 × 1	ge (In yrs. last birthday 91 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign intry)
	Director		Usual Residence of Decedent	21	71					OCT. 5,	1914	111	inois
	yland		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	B-f-	cto	MD Howard	l	Ellicott	City							1 ☐ Yes 2 No
	or 28	Oire	10e. Street and Number	_	-	10f. Zip					10g. Citizer	of What Cou	intry?
	hours after death with the Maryland turel', or Itema 23e or 28e-f ehow at Exer unerround be nutified at	Funeral Director	9461 Dunloggin F				042					US	
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces	?	Was Deceded	ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	14.	Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1 ☐ Yes 2	No No	Specify:			Sp	ecify: wh	nite
21215-0036	72 hours natural',	ed	15. Decedent's E		16a. Dec	edent's Usua	I Occupa	ition			16b. Kind	of Business/li	ndustry
215	5	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	(Giv	e kind of won DO NOT us	k done d	lurina mosi	t of worki	ing			•
21	D D =	mo.	12	- Conlogo (1 voi		emaker					Own	n Home	
p	be filed ital Hygind of other event, I	Be (17. Father's Name (First, Middle, Last)						First, Middle,		mame)	
yla	should be nd Mental marked o	၉	Frank Franta							Vanour			
Maryland	s 1 and 2 should f Heelth and Men Item 27 is marks other traumatic		19a. Informant's Name/Relationship (***						a/ Route Numbi			
	s 1 and 2 of Heelth a Item 27 is other train		Carol Berthold - 20a. Method of Disposition	daugnter	20b. Place of Disp			Roac		llicott		tion - City or T	21042
٥	Pages nent of I int: if it		1 Burial 2 XCremation 3		cemetery, cre	matory or ot	her place	9)					
Baltimore,	it. Partme		4 Donation 5 Other (Special Signature) Funeral Service Lices		Metro C	remato 2. Name and	-	s of Facilit		5/2006	Cato	nsvill	e, MD
Ba	permit. Pages Department of I Important: If It any injury or o		Christing !	aully	MU1319	Witzke	∍ Fui	neral	. Hom	es, Inco	Jumbi	- M	21045
	_		23a. Part1. Enter the disease, or com	plications that cause	d the death. Do not er							a, MD	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final				rlee	. 4					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		rointesti	14) (J-1 ec					-	Zd
	Examiner		Conventially link and distance	den	nentia								l yr
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as	a consequence of):								/
	sate be executed oblysician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C									
8760,	clan a			Due to (or as	a consequence of);								
387	death certificate be executed e ettending physiclan and ad for use as the burial-transi	dicai		_ d.									
9 X	eath certific ettending p i for use as i	an/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy						230	I. Date of deliv	/en/
Вох	death e etter d for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1⊡Live birth 4⊡Pregnant a		□Ectopic pre □ Other (spe					200	Month	Day Year
o.	that the de ed by the detached	Physicia	9 Unknown	9□ Unknown									
٥,	de de	by P	Part II. Other significant conditions	contributing to death I	out not resulting in the	underlying ca	iuse give	n in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
Vital Records,	The law requires ite has been sign bege 2 should be		Hypertensi	on						10	Yes 2	√o 3∏Pro	bably 4 Unknown
၁၁	e law re has be je 2 sho	Completed	Osteo poros!	S						24a. Was		4b. Were aut	opsy findings available
æ		No.	l								20 No	death? 1 ☐ Yes	2□ No
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?				1			(Check only o			
of	Physic this c	ဥ	1 ☐ Yes 2 ②No		ent 2 ER/Outpatie			4 ENVU		me 5 Resid			fy)
nc		ion	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Inj. (Month, Da	ury 28b. Time ny Year) Injury	M 28	Bc. Injury Work	rat ⊲? ∕es 2∐I		28d. Describe l	now injury o	ccurred	
Division	ten leat tor: the	licat	2 Accident investigatio 3 Suicide 6 Could not b	e 29a Blace of In	jury - At home, farm, s			163 201		28f. Location (Street and N	lumber or Rur	al Route Number,
<u>S</u>	efter Dire	Certification:	4 Homicide determined	building, e	tc. (Specify)	,				City or Tox			
	To the Hospitel or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 12 Certifying Pl (Check only one) 2 Medical Example one)	nysician: To the best miner: On the basis of and manner si	of my knowledge, dea of examination and/or i tated.	th occurred a nvestigation,	it the tim	e, date an	d place, a	and due to the ed at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
	To the h within 24 To the F complete	Me	29b. Signature and title of pertifier	/		29c.	License	number			29d. Date s	igned (Month,	Day, Year)
	/) toll	/	- UD)4	141	3		4.2	5.0	6
1	W		30. Name an address of person o	completed cause of	death (Item 23a) (Type	, Print)						. 0100	
1	V.		Paul G. Auwaert		10753 Fall	s Rd.	Ste.	325	, Lui	cnervil	ie, Mi	7 21093)
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. Regist	rar's Signature	Logoth 1	9						
- 4	MH 17 Rev 1/2		MILLA	2000	was is the	The state of the s							

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** YRUM WILLIE 0319 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2009 Harbour Gates Apt. 148 Annapolis Anne Arundel 8. Date of Birth (Month, Day, Sept 8 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 M ADE 579-28-8594 79 Yrs. 1926 Virginia Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo MarylandPrince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? is 1 and 2 should be filed within 72 hours after deeth with of Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or items 23e or other treumatic event, If a Medical Exactlest must be a 16 B Crescent Rd. 20770 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. should be filed within 72 hours after nd Mental Hygiene.
marked other then "naturel", or item 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXVo Specify ≱ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress 10thRestaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Manning Essie Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Byrum(Son) 8411 Spruill Dr. Bowie, Md. 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Importent: If ite
any injury or of 1 Burial 2 Cremation 3 Removal from State 4-28-06 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wm. Reese of Earlisons Mortuary, Lavry · Keese MOOS 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 30 KQ resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed certificete 1 ☐ Yes 1 ☐ Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? DAUGHTER Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 3□ DOA 2 ER/Outpatient this Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours e To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a Certifie nanner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hip completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 2^{Day} 2006 Ronald E. Brown Jr. 4:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Health & Rehab Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**⊡**M 2□ F 216-84-9813 45 Yrs. Jan 9 Director Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ehow in then "natural", or iteme 23a or 28e-1 ehove the Wedical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2X No Pasadena Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 445 Harlem Ave 21122 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 12th item 27 is marked othe other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ronald E. Brown Sr. Deanna Pettigrew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Deanna Miller (Mother) 445 Harlem Ave Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of c好便呀) (文字表的) 20c. Location - City or Town, State ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. 4-26-06 Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Lavy H. Reese Mc6483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final humadficeence Adured **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ been signer should be o aulue 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes l irector, page 2 s performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No the within 24 hours after deat To the Funarei Director: completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar 2006

			For State Registrer	State of Marylar		artment of rtificate o		Mental Hy	giene	6	13321
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year.	3. Time of Death
	/Medic			Byers				APRIL		006	5.50A M
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Death	1	4c. County		
			5. Social Security Number 6. Sex			If Under 1 Year	SUINIC ar If Under 24 Hrs.	8. Date of Bir	Anne		
	Funeral Director			M 2□F 89	Yrs.	Months Day	s Hours Min.	8. Date of Bir (Month, Da 10-27-	1916	Cour	place (State or Foreign htry) NC
			Usual Residence of Decedent								.,,
	Marylan-f show	tor	MD 10b. County Anne Aru:		ity, Town or Li Glen	Burnie				1	0d. Inside City Limits 1 ☐ Yes 2 🎇 No
	deeth with the Maryland ma 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 1035 7th Street			10f. Zip Code 210			10g. Citizen of V USA		ntry?
	na 23	era		12. Was Decedent Ever in U	J.S. 13.	Was Decedent o	f Hispanic Origin? (S	pecify Yes or No			an Indian,
36	after or its	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Co 1 ☐ Yes 2 🗓 N	f Hispanic Origin? (Suban, Mexican, Puert Io Specify:	o Rican, etc.)	Specify	ck, White, /: whi	
~ 9	2 hou	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occ	cupation		16b. Kind of Bi	usiness/Inc	dustry
215	hin 7:	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work dor DO NOT use reti	ne during most of wor ired)	king	C	4 4	
ane 1	d wit	Completed	12		E	lectrici	lan		Cons	truct	lon
eta yers , Francis Baltimore, Maryland 21215-0036	is t and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "naturel; other treumatic event, the Madical Exa	To Be (17. Father's Name (First, Middle, Last) Carl E. Byers				18. Mother's Nan	ne (First, Middle a L. Kan		10)	
Mary	d 2 shouth and M 7 is martreumat		19a. Informant's Name/Relationship (Ty Mrs. Peggy Sue Cam			-	et and Number or Ru		er, City or Town,		Code)
ers ore, N	t an Heali		20a. Method of Disposition	206.	Place of Disp	osition (Name of	1	Date	20c. Location -		own, State
) /e	Pages nent of int: If it	١,	1 Burial 2 □ Cremation 3 □ R Donation 5 □ Other (Specify)			matory or other p en Cemet		/2006	Glen Bu	-	
\mathcal{L} Balti	permit. Departm Importa any inju		21. Signature of Fundal Service License	M0136	54 1	2. Name and Add Second	dress of Facility S Ave SW G16	ingletor en Burni	n Funera Le MD 210	1 Hon 061	ne P.A.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CHOLAMETO	ENRIZ	to many	-				Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence of):	21 40 1100					
	Examiner		Samuelially list over this ex-	GORONARY	* AR	ERY	JISTASE				
7	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	- 0				
V	ecute and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conse		DISEN	35				
760,	ate be executed hysician and the burial-transit			Due to tor as a conser	quence on.						
~~~	physic the	dlcal		i.							
99 X	ding se as	/Me	IF FEMALE:	3c. If yes, outcome of pregn	iancy				23d Da	te of delive	20/
.О. Вох	ne death certificate I the attending physi hed for use as the t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnar □ Other (specify)				nth	Day Year
۵.	requires thet the de een signed by the a hould be detached f	by Ph	Part II. Other significant conditions cor	ntributing to death but not re-	sulting in the u	ınderlying cause	given in Part I.	23e. Did t	lobacco use cont	ribute to th	ne cause of death?
ords	w requires been sign should by	ted b						10	Yes 2□No	3 Prob	pably 4 Unknown
Division of Vital Records,	e law hes b	Completed				<del></del>		24a. Was auto perfo 1 \( \text{Yes}		Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of
ta	ilcian: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea				22,10
>	Physician: r this certifice ral director, p	To B	examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	] ER/Outpatie	nt 3 DOA	Other: 4 Nursing H	lome 5 ☐ Resi	dence 6 🗆 Oth	er (Specif	y)
o uo	5 5 5		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	V	ljury at Vork? □ Yes 2 □ No	28d. Describe	how injury occur	red	
Divis	or Attendir after death. Director: At in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, st ify)	reet, factory, offic	Ce -		Street and Numb wn, State)	er or Rura	al Route Number,
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co	(Check only 2 Medical Exami	sicien: To the best of my kn ner: On the basis of examin	owledge, dea ation and/or in	th occurred at the	time, date and place y opinion, death occu	l , and due to the irred at the time,	cause(s) and ma	anner as s and due to	tated. o the cause(s)
	thin 2 thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number		29d. Date signe	d (Month.	Day, Year)
	F \$ F 8		1 Boll Sold		ms		45149		April 2	27 -	2006
	12		30 frame and address of person who co	0. 1	h 1			(00.000)	e mi	. ~	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	reu (	7	gren	90140	.,,()	3	1001
	Regist		APR 2 8 200	6 Falence 1	S Par	alk)	<i>→</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

20	OK	13	2	2
CU	UU	1 12	1,7	do-good

		Registrar Certificate of Death	Reg. No.
Physicia	A1 10	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year  3. Time of Death
Medical Exami	ner	Earline Bradshaw	April 21, 2006 0906 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deal	th 4c. County of Death
		Mercy Hospital Emergency Room Baltimore	
Funeral		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi	15
Director		214-54-464 1 M 2XF 56 Yrs. Months Days Hours Mi	n. 8-20-49 Foreign Count Mary Jan
	H	Usual Residence of Decedent	10 29 1 Mayrac
any	ŀ	10a. State 10b. County 10c. City, Town or Location	10d Inside City Limits
ě .,		MN BOLLING	1 <b>X</b> es 2 No
Maryland 28a-f show d at once.	횽	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
Mar r 28a	Director	1 1 1	log. Citizen of What Country?
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once		1631 Lochwood Road 21218	USA
h wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (3. Married Armed Forces? If Yes, specify Cuban, Mexican, Puerline Armed Forces?	
deati or ite	اج	1 Yes 2 No	Plack
	ğ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Specify: DICCIC
136 hin 72 hours after than "natural", edical Examiner		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re	
2 3	뺼	Elementary/Secondary (0-12) College (1-4 or 5+)	1-h-1-1
036 ithin ne r tha		House keeping	PATEL
15-0036 filed within 72 hours after Hygiene ed other than "natural", t, the Medical Examiner	Completed	17. Father's Name (First, Middle, Last) 8.Mother's Name	ne (First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	Earl H. Bradshaw Lilli	an Edwards
21 Duld I Mer		19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number of	Rural Route Number, City or Town, State, Zip Code 313
MD d 2 sho lth and n 27 is	1	ROLIN ANN MOORE (Daughtett 400 Dar Vha.)	rive Dillastown PA
		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore permit Pages 1 a Department of He Important: If it		1 Burial 2 Cremation 3 Removal from State crematory or other place)	1/20/06 ROLLing MIN
		4 Donation 5 Other Specify: KING MEMORIAL TRUE	TIZINO DUTINOIS, NU
Baltii permit Departm Departm Importa		21. Signature of Funeral Service Licensee	ene tuneral Services
	17 Y	4905 you're	a, Balto MD 21212
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	Between Onset and
xaminer	1.4	Immediate Cause (Final disease a. Coronary Artery Thrombosis	Death
		or condition resulting in death)  Due to (or as a consequence of):	
	L	Sequentially list conditions, b. Atherosclerotic Cardiovascular Disease	
	<u>.</u> e	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
ecuted and - transit		d.	
760, ficate be execute g physician and the burial - tran	an/Medical	UNPENDED AMENDED	
50, te be ysici	led	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
68760, ertificate be ding physic e as the bur	2	23b. Was decedent pregnant in the 1 Live high	
c 61 cert endir use a	Sia		
Box e death c the atten	ysi	1 Yes 2 No 9 Unknown 9 Unknown	
y, P.O. Box 687 rres that the death certifi signed by the attending be detached for use as t	Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
P.O.	by	End Stage Renal Disease, Diabetes Mellitus	1 Yes 2 No 3 Probably 4 Unknown
15, quire en sig uld b	Completed by		24a. Was an 24b. Were autopsy findings available
cords aw requi nas been 2 should	訚		autopsy prior to completion of cause of
Rec The la icate h	티		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Reco rian: The law certificate has		25. Was case referred to medical 26.Place of Death (Chec	
Division of Vital Records, piral and arctuding Physician: The law require ours after death crall Director: After this certificate has been si filled in by the funeral director, page 2 should b	Be	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nurs	sing Home 5 Residence 6 Other:
of Vi ing Physi After this uneral dir	<u>유</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d Describe how injury occurred
ding h : Af e fun	Certification:	1 Natural 5 Pending (Month, Day, Year)	
SiO Atter deat	cat	2 Accident Investigation	200 Landing (Charles and Number on Burnel Burnel Burnel Burnel
lor after Dir	Ę	3 Suicide 6 Could not be determined (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Spita spita nours neral	Ö	Homicide (Speakly)	
e Hos n 24 ho e Fun letely	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	a at the time, date and place, and due to the cause(s)
- > - 0	Ž	29b. Signature and title of certifier 29c. License number	29d Date signed (Month, Day, Year)
		O.C.M.E.	April 22, 2006
3		30. Name and address of persor who completed cause of death (Item 23a)	
- / I			
		Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore,	MD 21201
	tate		MD 21201

06-02815 Phoenix White

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

3	product.			. "	13	13	,
2	11	1 1			ed,	1	
Loren	U	1 . 1	1	1.1	1.7	5	5

		- For State Certificate of Death Reg. No.								10 10020			
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,La					2. Date of Dea Month April 26, 2	Day Year	3 Time of Death 0406 hrs				
- who		4a. Facility Name (if not institution, g Sinai Hospital			4b	. City, Town, or L Baltimore	ocation of Di	eath	4c. County of E	Death			
Funeral Director	ľ	1/A 1	Sex 7. Age (	In yrs. last birl	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4Hrs. 8. Date of Bir Min. 11–19–	È	Birthplace (State or preign Country) Canada			
ow any	Ī	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City  Relitimore 1 X Yes 2											
ith the Maryland 23a or 28a-f show notified at once.	~ L	MD NA  10e. Street and Number  5512. Haddon. Avenue				10f. Zip Code 21207		1	10g. Citizen of What Country?				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced of Dates:			If Yes	Decedent of Hisp , specify Cuban, res 2 X No	Mexican, Pu	( Specify Yes or No lerto Rican, etc.)					
Nore, MD 21215-0036 ges I and 2 should be filed within 72 hours a nt of Health and Mental Hygiene. t: If item 27 is marked other than "natura other traumatic event, the Medical Examin	Completed by	15. Decedent's Education (Specify Elementary/Secondary (0-12)			Usual Occupation Usual Occupation of working life.			ne 16b. Kind of Business/Industry  NA					
21215-0036 July be filed within 7 Mental Hygiene, marked other than te event, the Medical	Be Com	17. Father's Name (First, Middle, La David Falls	st)			] 1		lame (First, Middle, egan Cooke	Maiden Surname)	urname)			
MD 2121 tod 2 should be fi thh and Mental m 27 is marked aumalic event,	]٤	19a. Informant's Name/Relationship Megan. Cooke/ Mother		407 R	eisterstow	m Road	Rm 244 Balt	mber, City or Town, timore, MD 2	21208				
E 2 3 E F		20a. Method of Disposition  1		crema	lace of Disposition (Name of cemetery, rematory or other place)  g Memorial Park  22. Name and Address of Facility			Date 5-01-06		ndallstown, MD			
		23a Part I. Enter the disease, or cor	r St. Balto,										
Physician Medical xaminer		failure. List only one cause on	each line. a. Smoke inhalation Due to (or as a consequence)	and Therr				,		Between Onset and Death			
	Examiner	Sequentially list conditions, b											
executed in and il - transit		events resulting in death) Last  UNPENDED											
Box 68760, ne death certificate be executed the attending physician and red for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23d. Date of de Month	olivery Day Year									
	Completed by	24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2 ✓ No 1 Yes 2 No  25. Was case referred to medical 26. Place of Death (Check only one)											
/ital sician: is certi	Be	25. Was case referred to medical examiner?	ursing Home 5										
on of Vital Fending Physician: ath ir: After this certifi he funeral director,	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending		28b. 030	how injury occurred inside house involved in fire								
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Copecify Multi-Family Apt.  28e Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or R or Town, State)  5512 Haddon Avenue, Apt. A											
To the Hospital within 24 hours	Medical (	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started  (Oheck only)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  and manner stated.											
	2	29b. Signature and title of certifier			O.C.N			April 26, 200					
3			no completed cause of de tant Medical Exami			reet, Baltimo	re, MD 21	1201					
Si Regis	ate trar	31. Date filed (Month, Day Year)	32. Registrar's	Signature	A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR	seli.							

			For State Registrar		State o	f Maryla		artmen rtificat			and M		Reg. No.	0.0	6	133	21,	
	Dharaisi		Decedent's Name (First, Middle, Last)									2. Date of De Month	ath Day		Year	3. Time	of Death	
	Physici: /Medic	_	Wanda Viole	t Co	X							April	24	, 20	006	9:24	A M	
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D															
			Hill Meadow	100		7 4 //	last blat da		r KSV	ille		C Data of Ric		Howard  9. Birthplace (State of				
	Funeral Director		5. Social Security Number  234-44-4516  Usual Residence of Decedent	6. Se	M 2 <b>∏</b> F	89 (In yrs	. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Oct 25	, 1916	7 6	Сои	Virg	_	
	yland low		10a. State 10b. Cour	nty		10c. C	ity, Town or L	ocation				-				10d. Inside	City Limits	
	Mar.	ţċ	Maryland Howa	rd		E	llicot	t Cit	У							1	s 2 No	
Maryland 21215-0036	h with the 23a or 28 In the not	al Director	10e. Street and Number 9044 Furrow Avenue 10f. Zip Code 21042								10g. Citizen of What Country? United States							
	irs after deal	by Funeral	11. Marital Status  1 Never Married 2 M 3 XWidowed 4 Divorce	arned	Armed Forces?  1			Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:  dent's Usual Occupation be kind of work done during most of work DO NOT use retired)  memaker				ecify Yes or No Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: White b. Kind of Business/Industry  home				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "naturel; or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at once.	To Be Completed	15. Decec (Specify only hig Elementary/Secondary (0-12	hest grade!)								ing	16b. Kii					
	uld be fited and Annal Hygie riked other title event, It		17. Father's Name (First, Middle, Last)  18. Mother's								e (First, Middle Cy Murr		9)					
	ind 2 shoralth and h		19a. Informant's Name/Relation Peggy May Tur			nter						al Route Numb e, Tenr				Code)		
J.	of He of He litem		20a. Method of Disposition	- 2 🗆 🗆	Community from	Ctoto	Place of Disponentery, cre	osition (Na matory or o	me of other plac	(e)	1	Date	20c. Lo	cation - (	City or T	own, State		
Ē	Page nent ant: If		1 🔯 Burial 2 □ Crematio 4 □ Donation 5 □ Other			Ce	edar Hi	ll Ce	mete:	ry	4/27	/2006	Broo	klyn	ı Paı	ck, Ma	aryland	
Baltimore,	permit. Departr Imports eny Inj		21. Signature of Funeral Server Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 2122											<b>22</b> 9				
	Physician	-5314	23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	or compl ist only or	ications that one cause on e	each line.	eth. Do not en		de of dyin	ig, such as	cardiac	or respiratory a	arrest,			Approxim Interval B Onse an	etween	
	/Medical Examiner				Due to	(or as a conse	equence of):											
	nd ransit	Examiner	Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	Due to for as a nonsequence of:													
8760,	ate be executed hysicien and the burial-transit	cal	resulting in death) Last		Due to	(or as a conse	equence of):	-							_			
O. Box 68	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Completed by Physician/Med	FFEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify) 9 Unknown										2		d. Date of delivery Month Day Year			
<b>C</b> 2	w requires that to be a signed by should be detailed		Part II. Other significant cond	litions co	contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of d 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ L						
	The law ste has b				24a. Was an autopsy performed? 1 \( \text{Yes} \) 2 \( \text{PNo} \)									P	4b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No			
Vital	ucian: Th certificate rector, pag	Be	25. Was case referred to med examiner?		26. Place of Death (Check only one)													
<b>5</b>	ling Phys 1. After this funeral di	Medical Certification: To E	1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending 2  Accident investigatio		28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?							Home 5 Residence 6 Other Specify Living						
Divis	or Atte		3 ☐ Suicide 6 ☐ Co	ild not be emined									er or Rur	or Rural Route Number,				
	ne Hospitel n 24 hours a ne Funerel sletely filled		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									stated. to the cause	9(s)					
	withir To th	M	29b. Signature and title of cer	ifier	2 /		29	29c. Licens					_		Day, Year			
	di		En	1	we				177	2594	7		APR	76	26,	2006		
	6		30. Name and address of pers	on who co	ompleted cau	se of death (It		Print)	Mu	Kn	, 6	mnks	Vicas	11	m	210	29	
	Sta Regist		31. Date filed (Month, Day, Yo		32. F	Registra e Sig	7	100	NO.				-		-#			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Dorothy Camer 04 2006 8:05pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F 75 Hours 579-38-3843 Director 11-08-1930 Washington DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD Montgomery Takoma Park 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7008 Aspen Ave 20912 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private 5+ Chemist injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Parklim Lee Lai Ping Chew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirk Camerlingo/son 7008 Aspen Av Takoma Park MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 04-26-2006 4 ☐ Donation 5 ☐ Other (Specify) Beltsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service m01358 933 Gist Av Silver Spring MD 20910
Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deatl Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of) Examiner PIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-transi the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical th Year

page 2 should be

Certification: To

cal

been signed by

After this

Director:

within 24 hours a

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 15No 9 ☐ Unknown	23c. If yes. 1 □ U 4 □ P 9 □ U

23c.	If yes, outcome of pregnancy
	1 Live birth 2 Fetal deat
	4 Pregnant at time of death
	9□ Unknown

3 □Ectopic pregnancy 5 □ Other (specify)
5 Uther (specify)

7=		23d. Date of delivery		
Ectopic pregnancy Other (specify)		Month	Day	

2

ழ் II. Other significant conditions contributing to death but	not resulting in the underlying cause given in Part I.
metastatic bylast	Cancel
Clarinic Hepatitis	C Dolase
Cocco	

		tribute to the cau:	
1 🗌 Yes	2 No	3 Probably	4 🗆 Unknown

	24a. Was auto perfe	
	1 ☐ Yes	2 No
of Death (	Check only	one)

24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No

5. Was case referred to medical				26. Place of Dea	ath (Check only one)	
examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome 5 🗆 Residence	6 ☐Other (Specify
7. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Describe how in	jury occurred

1 Natural 2 Accident	5 Pending investigation	(Month, Day Year)
3 Suicide	6 Could not be determined	28e. Place of Injury - At

				(VI	''
Зө.	Place of building,	Injury - At home, etc. (Specify)	farm, stre	et, facto	ory, office

VI 1 Yes 2 No	
factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only	Certifying Physic	ian: To the best of my knowledge, death occu	rred at the time, date and place, and due to the	ne cause(s) and manner as stated.
one)	Z	r: On the basis of examination and/or investigated manner stated.	ation, in my opinion, death occurred at the time	e, date and place, and due to the cause(
29b. Signatore are	d title of certifier	/	29c. License number	29d. Date signed (Month, Day, Year)

Marai		an	MI)	
O Ning and address of paraon	uma aamala	and anyon of doath	(Itam 22a) (Tuna Brint)	

29c. License number	29d. Date signed (Month, Da	ij
D11000	nul 91. 0	)

	7		-			_	-		_		
20	Nikario	and	addrace	of porcon	who	complete	d cauca	of doath	(Itam 23	a) (Type, Pr	(tenir
JU.	HOUSE	anu	addiese	or berzour	MILLO	COMPIGE	u cause	OI papatii	(Itom 20	a, (Type, FI	1111/
	~		A 4	1		1 6		(10			

Spring MD2091	0

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2	1	1 1	100			13	7	-
and the same	1 4	1	1-		7	= 5	1	
Louise	100	100	1.7	k	1	3.0	Com	1

	1- For State Registrar	Certificate o	f Death	Reg. No.	2000 10020
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	James Clow		2. Date of Death Month Day April 24, 2006	Year 3. Time of Death 1742 hrs
	4a. Facility Name (if not institution, give stree Suburban Hospital	t and number)	4b. City, Town, or Location of Death Bethesda		County of Death Montgomery
Funeral Director	5. Social Security Number 216-82-4965 6. Sex	7. Age (In yrs. last birthday) 2 F 41 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min	_ `	DD/YYYY) 9 Birthplace (State or Foreign Collary Land
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatite event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 X Never Married 2 Married 1 1 2 3 Widowed 4 Divorced If Yes, or Dat 15. Decedent's Education (Specify only high	, Apt N-1604  Vas Decedent Ever in U.S. 13. Warmed Forces? 15 No Give Year es: 16 nest grade completed of the property of the complete of the property of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the	10f. Zip Code 20852  as Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 X No specify:  at's Usual Occupation (Give kind of Nost of working life. Do NOT use retiling the Stylist  18.Mother's Name Clara  g Address (Street and Number of F	vork done red)  (First, Middle, Maiden Doris  Rural Route Number, Cir	10d. Inside City Limits  1 XYes 2 No  zen of What Country?  U.S.A.  14. Race - American Indian, Black. White, etc.  Specify: White Gind of Business/Industry  Salon  Surname)  Schenick
Baltimore, N  Emit Pages I and Department of Health  Important: If item injury or other trau	20a. Method of Disposition  1 Burial 2 X Cremation 3 Re  4 Donation 5 Other Specify:  21. Signa ur Funeral Service Licensee  23a. Part I. Enter the disease, or complication failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  Burial 2 X Cremation 3 Re  24 Donation 5 Other Specify:  25 Donation 6 Donation 6 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 Donation 7 D	moval from State  20b. Place of Disposic rematory or of Smiths but  22 J. MOO 706 10 10 11 11 11 11 11 11 11 11 11 11 11	sition (Name of cemetery, her place)  rg Crematory Apr  yame and Address of Facility  Keeney & Basford	26,2006 S P.A. Funer	mithsburg, Maryland
7760, ficare be executed g physician and stree burial - transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	ured Aortic Dissection (or as a consequence of): (or as a consequence of):			
Box 68 e death certi the attendim ted for use a:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9  Part II. Other significant conditions contr	Pregnant at time of death 5 0	etal death 3 Ectopic pregnather (Specify)  underlying cause given in Part I.	23e. Did tobacco u	Date of delivery  Month Day Year  use contribute to the cause of death?  No 3 Probably 4 Unknown
Division of Vital Records, P.O. teal or stending Physician: The law requires that the rs after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	25. Was case referred to medical examiner?  1  Yes 2 No	il: 1	26.Place of Death (Check	24a. Was an autopsy performed?  1 ✓ Yes 2 Noonly one)	
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2 ledical Certification: To Be Comp	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Could not be 2 29a. Certifier	Ba. Date of Injury (Month, Day, Year)  28b. Time of Be. Place of Injury - At home, farm, stre  Specify)	1 Yes 2 No	or Town, State)	nd Number or Rural Route Number, City
To the Hi within 24 To the Fi.	(Check only one) 2 Medical Examiner: On the and results of certified 29b. Signature and title of certified 20. Name and address of person who complete the complete and address of person who complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete the complete t	' '	29c. License number O.C.M.E.	at the time, date and pla 29d [ Apri	
State Registra	31. Date filed (Month, Day, Year)	Medical Examiner 111 Peni 32 Registrar's Signature	n Street, Baltimore, MD 212	01	
	Laron Locke MD. Assistant I	Medical Examiner 111 Pen	n Street, Baltimore, MD 212		il 25, 2006

		1 - State of M		partment of I ertificate of	Health and Men Death	tal Hygien Reg. N	ZUUh -	13327
Physic	cian	Decedent's Name (First, Middle, Last)				ate of Death	ay Year	3. Time of Death
/Med	lical	George M. Callan  4a. Facility Name (If not institution, give street and number)	ar) ı	4h City Town	or Location of Death	DRIL 2	5, 2006 lc. County of Death	851 am
Exam	iner	Mexiand General	Lesso tal	Balti	nicke Cr	Ly	N/A	
Funera Directo		5. Social Security Number 6. Sex 7 6. Sex 1 1 M 2 F	Age (Inlyrs. last birthda 84 Yrs.	Months Days	If Under 24 Hrs. 8. D Hours Min. (A	ate of Birth Month, Day, Yea pt. 22,	9. Birthp Coun 1921 New	lace (State or Foreign try) YORR
and w		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or	Location				0d. Inside City Limits
Maryl Ited	tor	Maryland Baltimore	,	Parkvill	2e			1 ☐ Yes 2 ☑ No
ith the	Oirec	10e. Street and Number		10f. Zip Code			Citizen of What Coun	try?
e 23a	arai [	2707 Emerald Road	. 5		21234		1.S.A.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: It tlem 27 to marked other then "naturel", or Iteme 23a or 28a-t ehow any fluiny or other traumatic event. Its Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced  1 X Yes 2 If Yes, Give	s? □ No	If Yes, specify Cub	Hispanic Origin? (Specify Yan, Mexican, Puerto Ricar Specify:	res or No- n, etc.)	14. Race - Americ Black, White, of Specify: WM	
72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occur ve kind of work done	during most of working	16b.	Kind of Business/Inc	lustry
within the within	ompi	Elementary/Secondary (0-12) College (1-4c	r 5+)	o. DO NOTuso rotiro Chanic	d) -	Δ	ircraft	
e filed Hygi other	BeC	17. Father's Name (First, Middle, Last)	1 1.00	C.100,70C	18. Mother's Name (Firs			
Yar ould b Ments Ments arked	To	James Callan				zymore		
y, Maryland 21215-0036 and 2 should be filed within 72 hours att eeith and Mental Hygiene.  n.27 ie marked other then "naturel", or ne traumatic event. Its Madical Exemi		19a. Informant's Name/Relationship (Type, Print)  Don Mattes (executor)	4112	2 Pinedale	and Number or Rural Row Drive, Noti	tingham,	MD 2123	6
altimore, mit. Pages 1 ac partment of Hee portant: It Item;		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State	le	position (Name of rematory or other pla			Location - City or To	
Itin nit. Paratmer artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		Crematory 22. Name and Addre	ess of Facility Schur		timore, M	
Dal Depart		Megans Run	eken	9705 Bela	ir Rd., Bali	timore,	MD 21236	
		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	line.	1		piratory arrest,		Approximate Interval Between Onset and Death
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	TURY HR	HERY I	)isease			
Examine		A tri	al Fib	eillatio	N			
pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):					
18760, cate be executed physicien and the burial-transit	Examiner	that initiated events c./	as a consequence of):	010				
8760, sate be ex thy sicien the burial	dical	d						
ப ≝ கூ	Med	IF FEMALE: 23c. If yes, outcome						
vision of Vital Records, P.O. Box 6 Attending Physicien: The law requires that the death certific r death. ector: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	235. Was decedent pregnant in the past 12 months? 1 Ves 2 No. 4 Pregnant	2 Fetal death 3 at time of death 5	B Ectopic pregnancy D Other (specify)	y 		23d. Date of delive Month	ry Day Year
P.O	Phys	9 □ Unknown 9□ Unknown						
ds, signed d be d	d by	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tobacco 1 ☐ Yes	use contribute to th	e cause of death?
W requ	ete					4a. Was an		
Re la The la ate has	J mo				1	autopsy performed?	death?	osy findings available inpletion of cause of
/ita	Be	25. Was case referred to medical examiner?			26. Place of Death   Che			
Of Physic ruthis corral direction	2	1 Yes 2 No Hospital: 1 Inpa 27. Manngr of Death 28a. Date of Ir			4   Nursing Home	5 Residence Describe how inj		)
ion nding ath. r: Afte e fune	ation	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of In  (Month, I)	Day Year) Injury	Wor	rk? Yes 2 No	Social New III	ary occurred	
Division of Vital Records, P.O. Box at or Attending Physicien: The law requires that the death cers after death.  I Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building,	njury - At home, farm, s etc. <i>(Specify)</i>	street, factory, office	28f. L	ocation (Street a lity or Town, Sta	and Number or Rural te)	Route Number,
Division of Vital Rec To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Physician: To the besicane) 2 Medical Examiner: On the basis and manner	of examination and/or	ath occurred at the tir investigation, in my o	me, date and place, and di opinion, death occurred at	ue to the cause( the time, date ar	s) and manner as stand place, and due to	ated. the cause(s)
To the within To the comp	ž	29b. Signature and title of certifier		29c. Licens	se number	29d. D	ate signed (Month, L	Day, Year)
I ILLI		30. Name and address of parson who a montal source of	death (Hom 22a) (T	en Brint)	7536		7125/04	0
471		30. Name an address of person who moved cause of	777	TO M	aryland	Gierren	al Hos	peta
	tate	31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	Pr. so			/	
Regis		APR 2 8 2000 / 3	on A )	Borner J				
			ORIO	GINAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician SEBASTIAN APRIL CACCAMO 2006 11:45 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 217-03-4895 92 Director Oct. 7, 1913 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow If Itam 27 Ia marked other then "naturel", or Itams 23a or 28a-f abov or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2€ No Harford Bel Air Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21014 U.S.A. 1119 Sunset Drive death v by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. white Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "ns any injury or other traumatic avent, It a Madic one. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) automotive 5 years mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angelina Salamone Giovanni Caccamo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1119 Sunset Drive, Bel Air, MD 21014 Anna M. Caccamo/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 4/26/2006 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by irector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes aus or Attending Physician: After this certific funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ER/Outpatient 3□ DOA Certification: To 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending within 24 hours after death. To the Funarel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide o the Hospitel 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Apr. 121, 2006 P3227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN -615 W. MACPHAIL ROAD - STE 106 - BEL AIR, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan				ealth a Death	nd M	ental Hyg	iene)	06	3329
14	Physici	an	Decedent's Name (First, Middle, Last)	A	0.0	TEN	، رد:		***************************************		2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic		JOSEPHINE  4a. Facility Name (If not institution, give s	treet and numb	<u>·</u>	1/200			Location of	Death	04	7 \ 4c. Co.	2006 unity of Death	0/51 "
*	Examin	ier	Arundel Medical		0,7				apolis				ne Aru	indel
	Funeral		5. Social Security Number 6. Sex	7.	Age (In yrs.	last birthday)	If Unde	r 1 Year Days	If Under 2 Hours	4 Hrs.	8. Date of Birth (Month, Day,	Year	9. Birthp	lace (State or Foreign
	Director		212-64-5041	M 200-F	52	Yrs.	NOTICIS	Days	Hours	IVIIII.	July 25,			ngton DC
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	Maryl 4 •ho	ō	Maryland Anne Arus	del		Ann	cool	'S						1 XYes 2 No
	r 28a	Director	10e. Street and Number					p Code			10	0g. Citizen	of What Cour	itry?
	h with	ai D	1135 Madison St	reet	B 3		1	1403	•			US	A	
	me 2	Funerai	11. Marital Status	12. Was Decede	ent Ever in U. es?	.S. 13.	Was Dece	edent of Hi	spanic Orig	in? (Spe Puerto f	cify Yes or No- lican, etc.)		Race - Americ Black, White,	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	No		1 ☐ Yes		Specify:				ecity: Whi-	
21215-0036	72 hours after death with the Maryland *natural", or Iteme 23a or 28a-1 show diret Evanite frings to nullied a		3 ⊠Widowed 4 □Divorced  15. Decedent's Educ	Year or Date	es: 	16a. Dece	dent's lis	ial Occupa	ation				of Business/Inc	
7.5		Completed	(Specify only highest grade	completed)		(Give	kind of w	ork done d	during most	of workir	ng	TOD. INITIO	Or De31110334111	Justiy
212	d within giene. ir then "	E O	Elementary/Secondary (0-12)	College (1-4	OF 5+)	74.	emer	nake				00	wn Ho	me
5	be filed tal Hygi d other event,	Bec	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle, M	Maiden Sur	mame)	
yla		2	William Conrad		er III						May			
Maryland	and and le m		19a. Informant's Name/Relationship (Ty)		,		•				Route Number	•		
	s 1 and 3 f Health Item 27 other tr	1	Tennifer Stevens /	Daugh		945 C			ve w		esbero		22486 ion - City or To	
Baltimore,	S to to to		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from St	ate . c	emetery, crei	natory or	other plac			,2006		,	
量	permit. Pag Department Important: I any injury o		4 ☑ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	AA	AAO	tomy Gi					tomy Gift			
Ba	permit. Departr Importe any inje		161			1					wite P		,	21076
			23a. Part1. Enter the disease, or compli	cations that cau	sed the deat									Approximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final		) a 4	m	TAK	THE	7 (	1.	NG	( AN	150	Onset and Death
35.	/Medical		disease or condition resulting in death)		as a conseq		- 11/	, ) / \ [	1 C		1 - 4	C/11*(		
	Examiner		Sequentially list conditions.											
	p #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):								
	and Ftrans	Examiner	that initiated events resulting in death) Last		as a consequ	neuce of):								
8760,	ate be executed obysicien and the burial-transit	Icai E				201100 01.71								
687	death certificate be executed e attending physicien and nd for use as the burial-transit	adic	d											
Box (	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outco								23d.	. Date of delive	эгу
m.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnar	h 2□Feta nt at time ol d		JEctopic ( ☐ Other (s	pecify)					Month	Day Year
P.0	at the de by the	hys	9 ☐ Unknown	9∐Unknow		_								
	es tha	by	Part II. Other significant conditions con	tributing to dea	th but not res	ulting in the u	nderlying	cause give	en in Part I.					ne cause of death?
Records,	v requir been s	Completed									11276	s 2 N		ably 4 Unknown
lec	e law has b je 2 st	npie									24a. Was a autops	y	4b. Were auto prior to co death?	psy findings available mpletion of cause of
E H												No	1 Yes	2 🗆 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		5510		Othi	25		(Check only on		301 (0.1	
ō		1: To	1 Yes 2 No  27. Manner of Death	28a. Date of	Injury	ER/Outpaties 28b. Time o		28c. Injun Worl	4 LI Nur		ne 5 Reside			y)
O	Attending For death.  ector: After by the funer	ţi	1- Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	м		k? Yes 2 ∐N	No				
Division	or Attendiater death.  Director: A	ifica	3 Suicide 6 Could not be 4 Homicide determined		f Injury - At he		reet, lacto	ry, office		- 2	281. Location (SI City or Town		lumber or Rura	I Route Number,
Ö	tal or A rs after al Dire	Certification:		Dalloing	j, etc. (Specif	,,					0.19 01 10W	., 0.410/		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical (	(Check only one)	ner: On the bas and manne	is of examina	wledge, deal ition and/or in	n occurra vestigatio	n, in my o	te data tino pinion, deat	d plane i h occurre	and due to the or ed at the time, d	70%(\$) 3h ate and pla	d manner has ace, and due to	taled the cause(s)
	withir To th compl	Me	29b. Signature and title of certifier	/)				c. Licensi		_	C 2	9d. Date s	igned (Month,	Day, Year)
		5	Am I to	Ten?	12 m				21	43	8	HAR	N 52	2006
			30. Name and address of person who co	h leted cause	of death (Iten	n 23a) (Type	Print)	101	0 10 -	- ป		Δ.	VA DA: 15	2006 W D21401
			MICHAR J. Lai	ENTY	· /~/	441	\	1500	NSE	111	dhimm	/ Pu vi	VTX-04)	VV(   ) V( Y U)
8	Sta Regist		31. Date filed (Month, Day, Year) APR 2 8 2006	32. Reg	gistrar's Signa	ature	200							

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland / Dep	partment of Hertificate of I	lealth and N	_	2006	13330	)
	A		Decedent's Name (First, Middle, Las	*1				2. Date of Death		3. Time of Dea	ath
41	Physici	an						Month	Day Year	10.00	PM
i a	/Medic		Charles Willia		-11, 50.			April 22	-	10.33	1
	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of Deatl		
11			Chesapeake	Woods No	irsing Hom	e Can	bridge		Dorches	iter	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthda)	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birti	nplace (State or Fountry)	reign
2.0	Director		219-44-1560	<b>X</b> M 2□F	59 Yrs.	Months Days	Hours Ivial.	June 26,		aryland	
9.00	*		Usual Residence of Decedent								
	land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Li	imits
	Aary	ō	Maryland Carolin		Maryd	15				1 Yes 2	□No
	88a-	ect	10e. Street and Number	, E		10f. Zip Code		100	. Citizen of What Co	unto?	
	or it	급		D /		210	0 U O	1.09	USA	,	
	23g	Funeral Director	20 Marydel								
	de.	ine	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	<ul> <li>Was Decedent of H If Yes, specify Cuba</li> </ul>	lispanic Origin? (Sp an, Mexican, Puerto	Decity Yes or No- Dican, etc.)	14. Race - Ame Black, White		
9	afte or it	F	1 Never Married 2 Married	1 XYes 2 □ N If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Specify: Wi	rite	
8	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Examiner must be multiled at	l by	3 ☐ Widowed 4 M Divorced	If Yes, Give Year or Dates: I	461-1464						
2-0	72 h	tec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dec	edent's Usual Occup re kind of work done of DO NOT use retired	ation during most of work	king 16	b. Kind of Business/	Industry	
2	within ene.	id	Elementary/Secondary (0-12)	College (1-4or 5					Construc	4:	
21215-0036	in the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	Completed	7		116444	Equipment	Operator		CONSTRUC	TION	
0	othe	Bec	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	iden Sumame)		
ם	d be enta Ked	To B	William Tilo	hman Cal	nall		Edit	h Kemp			
>	12 should be filed within 7 n and Mental Hygiene. 7 is marked other than "r raumatic event, the Mad	-	19a. Informant's Name/Relationship (7	vpe, Print)	19b. Ma	iling Address (Street	and Number or Ru	ral Route Number, (	City or Town, State, 2	Zip Code)	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event. The Madical Examiner must be notified at		Charlotte Cahall	•	F P.O.	Box 1102	Cambri	das M	D 21613		
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition	, , ,	20h. Place of Dis	position (Name of			c. Location - City or	Town, State	
5	or of h		1 Burial 2 Cremation 3	Removal from State	l comptant of	romotoni or other alai	(April 5				
Baltimore,	Pag ment: ant:		4 Donation 5 ☐ Other (Specify		Matomy (	Gifts Regis	try print	-5,2006	Hanover,	1~( +>	
a	permit. Departimport any injure.		21. Signature of Funeral Service Licen	see		22. Name and Addre					
m	80E = 8		15		-	1522 Conn	elley Drive	Suite P.	Honever, M	ID 21076	
de y			23a. Part 1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final	one cause on each lin	IA .	enter the mode of dyir				Approximate Interval Betwee Onset and Dea	
	Physician /Medical		disease or condition resulting in death)	a		anora n	001.011	0107100		years	
	Examiner			Due to (or as	a consequence of):						
		L	Sequentially list conditions,	b							
day	p =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
	be executed sicien and burial-transit	a	Cause (Disease or injury that initiated events	c							
Ó,	en a rial-	Ä	resulting in death) Last	Due to (or as	a consequence of):						
760,	sicien suria	cai	•	d							
68	ficat ph)	edi									
	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transi	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of del	ivery	
Вох	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		3 □Ectopic pregnanc 5 □ Other (specify) _	у		Month	Day Yea	ır.
o.	at the de by the a tached	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
P.0	that the	<u>q.</u>	Part II. Other significant conditions of	cotributing to death hi	ut not resulting in the	underlying cause as	ven in Part I	23e. Did toba	cco use contribute to	the cause of deat	
	igne bed	by	/1-/		at not resulting in the	didenying cause git	on are ares.			obably 4 Mnk	
p	en sl	ed	Renal care	,				1 1 1 1 1 1 1 1	2010 301	obacily 4	1101111
S	s been s been s shoul	Completed	Kenal Care	mona				24a. Was an autopsy	24b. Were at	utopsy findings ava	ulable
Re	The lav	Ē						performe	ed? death?	2 □ No	
त्व			25. Was case referred to medical				OC Place of Doc	1 ☐ Yes 27 ath <i>Check</i> only one		20140	- 57
Ę	ysician: is certific director,	Be	examiner?	Hospital:		Ott					
of	Phys this al di	2	1 ☐ Yes 2 No	1 U Inpatie			and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	28d. Describe hov	ce 6 Other (Spe	ciry)	
2	ding F h. After funer	0	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Dat		y Wo	rk?	200. 20301100 1101	injury occurred		
.00	att : ac	ati	2 Accident investigation 3 □ Suicide 6 □ Could not b				]Yes 2□No				
Division of Vital Records,	or Attencafter death Director: in by the	tif	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injusting, et	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stree City or Town,	eet and Number or R State)	ural Route Numbei	τ,
Ö	To the Hospital or Attuvithin 24 hours after de To the Funeral Directo completely filled in by the	Certification:									
	hour hour mera y fille	<u>a</u>		ysician: To the best							
	• HG • Fu	Medical	(Check only 2 Medical Exer	niner: On the basis of and manner sta		nvestigation, in my	оріпіол, аватп оссі	irred at the time, dat	e and place, and due	o trie cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certified	201	4	29c. Licen	se number	29	d. Date signed (Mont	th, Day, Year)	
	⊢ ≯ ⊢ ŏ		11/4	21027	IND	D	25933		4,741	6	
			1111	-/	- Av		-100		1.000	~	
			30. Name and address of person who	completed duse of	eath (Item 23a) (Ty	pe, Print)	7/1/1				
			010 1/194	MANAL FO	une, the	5/09/100	11001				
18		ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature						
	Regist	rar	APR 2 8 2006	A Professor	As Ass.	360					

DHMH 17 Rev 1/2001

06-02625 Please Type or Print in Black Indelible Ink Davon Thomas Curtis State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day April 18, 2006 **Medical Examiner** 0637 hrs 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Dea Sinai Hospital **Baltimore** 5. Social Security Numbe 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth/MM/DD/YYYY 9 Birthplace (State of Director Hours oreian 1 X M 2 Country) Yrs Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 No s 23a or 28a-f show e notified at once. Director 10e. Street and Numbe 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No Marital Status Was Decedent Ever in U.S. . Race - American Indian, Black must be 1 Never Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Yes 9 other traumatic event, the Medical Examiner Widowed Divorced f Yes, Give Year Yes 2 No specify: Specify other than "natural", à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ MD 21215-0036 2 should be filed within hand Mental Hygiene Father's Name (First, Middle, Last er's Name (First, Middle, Maiden Surname) marked Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State If item 27 is 20b. Place of Disposition (Name of cemetery Date Baltimore, crematory or other place) **V** Burial 2 Cremation 12006 mportant: Other Specify Donation 5 nature of Funeral SerMice Licens Josep Ba t). Enter the disease, or complication ure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval 8 etween Onset and /Medical a. Stab wound of chest with complications ediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 1 V Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ဥ 1 V Yes 28a. Date of Injury (Month, Day Year) Apr 14, 2006 27. Manner of Death 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? Certification: Subject was stabbed Natural 0110 hrs Pending Yes 2 V No To the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined (Specify) Local Street 4 V Homicide 2600 block Loyola Southway, Baltimore, MD

Death

Year

29d. Date signed (Month, Day, Year)

April 19, 2006

DHMH 17 Rev 1/2001 **OCME 2006** 

29a. Certifier 1

29b. Signature and title of certifie

Ling Li, MD

31. Date filed (Month, Day,

(Check only

Medical

State

Registrar

ORIĞINAL

and manner stated

, mid 30. Name and address of person who completed cause of death (Item 23a)

8

Assistant Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License numbe

O.C.M.E.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #5 Per FH G855 5/25/0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , 2006 Year **Physician** April 25, Robert COX 11:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Homewood Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XX M 2□F Director Yrs. August, 1,1912 WestVirginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits ma 23a or 28a-f ahor 1√XYes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 616 East 33rd Street 21218 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ADN No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other than "natural", or item other traumatic event, the Modical Exertiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo White Specify: XXWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Remodeling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Cox Rose Guplet ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 East 33rd Street Baltimore, Maryland 21218 19a. Informant's Name/Relationship (Type, Print) DTR Rosemary Cox f Heelth 20a. Method of Disposition
1 ☐ Burial XX Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: if any injury or once. GreenMount Crematory | 4/27/06 Baltimore, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. Serve Ferrare 6500 York Road Baltim

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Physician Atheroseliste disease or condition resulting in death) Cardio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Ettas or injury that in its asserts. Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Dunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has l 2 No 1 ☐ Yes of Vital director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 No Other: 4 Fursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manny of Death 1 Matural iuneral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation after death. To the Hospital or Attandir within 24 hours after death.

To the Funeral Director: Al completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17537 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSH RN. 5. SRLW) A 1600 W MOUNT GOOW MOUNT ROYAL AVE, BALTIHORE MD 21217 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

06-02776 Alice T Dreyer

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death Month Day April 24, 2006 **Medical Examiner** 1248 hrs Aliœ Dreyer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death John Hopkins Bayview Hospital Baltimore Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 183-22-4473 Country) PA M 2 XF 76 November 14,1929 Usual Residence of Decedent 10a State 10b. County I0c. City, Town or Location 10d Inside City Limits Yes 2 X No 28a-f show permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: I friem 27 is marked other 140... or items 23a or 28a-f shomust be notified at once. New Castle Claymont Delaware 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8203 Governor Prince Blvd. 19703 USA Ճ Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married Yes Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify White Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 years Assembly Worker Electronics 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) æ Joseph W. Duaine Ruth A. Keely 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8203 Governor Prince Blvd, Claymont, Delaware 19703 Thomas E. Dreyer son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) Burial 2 XCremation 3 Removal from State Bayview Crematory 2006 Baltimore City, MD. 4 Donation 5 Other Specify 21 Signatur of Funeral Service Licenses Correlly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval -failure. List only one cause on each line Between Onset and /Medical Atherosclerotic cardiovascular disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical item#23a,27,perME,g856,6/16/06 TT X UNPENDED AMENDED attending physician or use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown <u>0</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) director, Be examiner? Hospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ို 1 V Yes After 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 Pending death. Funeral Director: stely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 25, 2006 30. Name and address of person who compl eted cause of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) sistrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

e ada

2006

			1 = For Stata Registrer	State of Maryl		artment of F rtificate of			giene	13334
vij er	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Year	3. Time of Death
1	/Medic	al .		HARLOTTE E.	DITTELL	45 Ch. T.	- L ( D )	April 2		4:00 A M
). 	Examin	er	4a. Facility Name (If not institution, give s 6 Knoll Ridge Cor 5. Social Security Number 6. Sex	ırt #1412		Balti	r Location of Deal LMOTE			e County
	Funeral Director			M 2XXF 97	yrs. last birthday) 7 Yrs.	Months Days	Hours Min.		, 1908 Ma	thplace (State or Foreigr ountry) ryland
	Maryland I-f show	tor	10a. State 10b. County  Maryland Baltimon		City, Town or Lo Baltimo					10d. Inside City Limits 1 ☐ Yes 2 X No
	with the a or 28s	Director	10e. Street and Number 6 Knoll Ridge Ct.,	#1 /.1 2		10f. Zip Code 21210			10g. Citizen of What C United St	•
36	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show he Medical Evaminer must be notified at	by Funeral		12. Was Decedent Ever if Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itsms 23a or 28a-f show any injury or other treumatic svent, the Medical Examiner must be notified at once.	Completed b	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	nrking	16b. Kind of Business department	
	ld be filed ental Hygia ked other ic svent, ti	e e	17. Father's Name (First, Middle, Last) Henry Bernard Voge.	[	, Di	ayer.		me (First, Middle, Lna Blome	Maiden Sumame)	Store
Maryland	12 shoul h and M 7 is merl treumati	1	19a. Informant's Name/Relationship (Ty, Janice Miller/daug)	pe, Print)		ng Address (Street	and Number or R	ural Route Numbe	or, City or Town, State, 11timore, M	
	ges 1 and it of Healt if item 2 or other		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	b. Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date	20c. Location - City or	Town, State
Baltimore,	permit. Pa Departmen Important: sny injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligense			. Name and Addre	II-Wiede	efeld Fun	Woodlawn, eral Home,	Inc.
3 1			23a. Parl 1. Enter the disease, or compli spock, or heart failure. List only or	cations that caused the ce cause on each line.		6500_Y	ork Rd.	Baltim	ore, MD 2	1212 Approximate Interval Between Onset and Death
,8760,	Physician /Medical Examiner be executed but is the burial-travet	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequanca of):	( 05	stact			
.O. Box 68	death certii e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	olivery Day Year
٥	quires that the signed by and be detacted	þ	Part II. Other significant conditions cor	tributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was autop perior 1  Yes	sy prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		oth Oth	00	ath Check only o		
ot		lon: To	27. Manner of Death  1 Natural 5 Pending	1 ☐ Inpatient  28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	4   Nuising i	28d. Describe h	lence 6 □Other (Spe low injury occurred	ecify)
Division	ten leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Abuilding, etc. (Sp	At home, farm, str ecify)		163 2 110	28f. Location (S City or Tow	Street and Number or R m, State)	lural Route Number,
-	To the Hospitel or At within 24 hours after o To the Funeral Direct completely filled in by	ledical C	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occi	e, and due to the ourred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
	0		Moca			DYI	1243	1	April 24	,2006
	8		30. Name and address of person who co	M.D., 1120	N. Roll		Catons	ville, Ma	ryland 212	28
100	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8	32. Registrar's S		pode				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month , **Physician** Davis Irene /Medical 2006 4e Fecility Name (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Deeth Examiner altimore romwell 7. Age (In yes. lest birthdey)
Yrs. 8. Date of Birth (Month, Day, If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (State or Foreign
 Country) **Funeral** Days 1□M 25 F -54-004 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health end Mental Hygiene. Int: if Item 27 ia marked other than "natural; or items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shor traumetic event, the Medical Examiner must be notified at 1 Nes 2 No Funeral Director 1 to more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 51 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry econdary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I important: If Ita any injury or ot 1 ☐ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M01363 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Lest Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 24/140 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Li. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier 29b. Signeture end title of certifier who completed cause of death (Item 23e) (Type, Print) 5601 32. Registrer's Signature Registrar

DHMH 16 Rev 6/95

	_	For State Registrar	State of Mary	C	ertificate of	Death		Reg. No	2006	13336
Physici	an	1. Decedent's Name (First, Middle, I					2. Date of Month	Day	Year	3. Time of Death 5:45am M
/Medi	cal	Olga Erin  4a. Facility Name (If not institution, g	Irene Davis		4b City Town	or Location of De	Apri		2006 County of Death	J:4Jaili M
Examir	ner	Augsburg Luther			Balti		,			
Funeral Director		185-16-0770		n yrs. last birthda Yrs.	Months   Davs		in. 8. Date of (Month)  June 2	Birth Day Yaar) 7,1918	Cou	place (State or Foreign ntry) sylvania
should be filed within 72 hours after death with the Maryland ind Mental Hygiene. In the Maryland in Maryland show marked other than "natural", or Items 23a or 28a-1 show matic event, the Medicul Eventi at the findling a	tor	Usual Residence of Decedent  10a, State 10b, County  MD	10	oc. City, Town or Gwyn	r Location nn Oak					10d. Inside City Limits 1 Yes 2 □ No
h with the	Funeral Director	10e. Street and Number 6811 Campfield	Road		10f. Zip Code 21	207		_	en of What Cou SA	ntry?
perritt. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exercities in that he notified an once.	by Funera	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	or in U.S.	13. Was Decedent of If Yes, specify Cut		(Specify Yes or erto Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh	
within 72 hou ene. than "natura he Medicul B	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Gi	ecedent's Usual Occu ive kind of work done e. DO NOT use retire Homemaker	pation during most of t ed)	working		od of Business/Ir	ndustry
ed other	o Be Co	17. Father's Name (First, Middle, La Albert D. Vaid					Name (First, Mide Fodor	dle, Maiden S	Sumame)	
nd 2 shour aith and Me 27 is mark r traumatio	Ţ	19a. Informant's Name/Relationship Eileen A. Davis			ailing Address (Stree					
Pages 1 a nent of Hea ant: If Itam ury or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5 Other (Spe	Removal from State	cemetery, c	sposition (Name of crematory or other pla n Memorial F	ark Ma	y 1,2006		sation - City or T sburgh, PA	own, State
Departr Mports Iny inji		21. Signature of Funeral Service Li	censee		22. Name and Addr	ess of Facility	a Danami	TI To		
Frivsician		23a. Part1. Enter the disease, or conshock, or heart failule. List or Immediate Cause (Final disease or condition	omplications that caused the hly one cause on each line.	e death. Do not	1501 Ea		ve Baltim	ore MD 2	nc. 21230	Approximate Interval Between Onset and Death
/Medical Examiner	Examiner		a Due to (or as a c	consequence of):	1501 Fa enter the mode of dy	st Fort A ing, such as care	ve Baltim	ore MD 2	21230	Interval Between
/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I any least the immediate cause. Enter Undertying Cause (Disease or injury that initiated events	a	consequence of):  consequence of):  consequence of):  pregnancy  Fetal death	1501 Fa	est Fort A	ve Baltim	ore MD 2	21230 21230 3d. Date of delive	Interval Between Onset and Death Onset and Death VIPO
/Medical Examiner	by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, large learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a	consequence of):  A consequence of):  pregnancy  Fetal death ne of death	1501 Fa	est Font A	Faltimodiac or respirator	y arrest,	21230	Interval Batween Onset and Death Onset and Death Violation Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activities Activit
/Medical Examiner	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, In the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknowh  Part II. Other significant condition	a	consequence of):  A consequence of):  pregnancy  Fetal death ne of death	1501 Fa	est Font A	23e. D  24a. W  appli	arrest,  2 id tobacco us  Yes 2 fas an utopsy strormed? s 2 fas 2 fas an utopsy	21230  3d. Date of delive Month  se contribute to SNo 3 Pro	Interval Between Onset and Death Onset and Death Act of the Cause of death?  Day Year  the cause of death?  bably 4 □Unknown opsy findings available ompletion of cause of
Examiner	Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any least in immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	consequence of):  A consequence of):  pregnancy Petal death ne of death	1501 Fa	est Font A ing, such as care  of  of  cy  liven in Part I.	Paltimodiac or respirator Foot	id tobacco us Yes 2	21230  3d. Date of delive Month  se contribute to the Secontribute to the Secontribute to the Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second	Interval Batween Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Dea
Physician: The law requires that the death certificate be executed to this certificate has been signed by the attending physician and this certificate has been signed by the attending physician and a line at the burial-transit of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any lead in the immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   yes 2   No 9   Unknowh  Part II. Other significant condition  25. Was case referred to medical examiner? 1   yes 2   No 27. Manner of Death   Natural   S   Pending	a	consequence of):  A sonsequence of):  pregnancy Petal death ne of death and resulting in the	atient 3 DOA	cy  26. Place of ther:  28. Place of ther:  28. Place of ther:  29. Place of there are the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place	23e. D 24a. W p peath (Check on	id tobacco us Yes 2	21230  3d. Date of delive Month  se contribute to the secontribute to the secontribute to the second death?  1  Yes	Interval Batween Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Dea
Physician: The law requires that the death certificate be executed to the certificate has been signed by the attending physician and this certificate has been signed by the attending physician and a line at the burial-transit of the certificate has the burial-transit.	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I any lead of the immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes 2   No 27. Manner of Death	a	pregnancy pregnancy Fetal death not resulting in the  2 □ ER/Outpa  28b. Tim Injur	atient 3 DOA	est Fort A ing, such as care cy  even in Part I.  26. Place of ther: 4 Nursin ury at ork?  yes 2 \( \text{No} \) No	23e. D 24a. W 24a. W 24a. W 24a. W 25g. Death (Check on 1) 28d. Descri	arrest,  2  id tobacco us  Yes 2  As an utopsy arrormed? s 2  No ly one) esidence 6 be how injury	21230  3d. Date of delive Month  Se contribute to the Secontribute to the Secontribute to the Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second	Interval Batween Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Dea
this certificate has been signed by the attending physician and air director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any lead in the immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknowh  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes 2   No   27. Manner of Death   Ponding investigate   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natu	a	pregnancy pregnancy prediction and the second sequence of):  pregnancy pregnancy prediction and the second sequence of):  2 □ ER/Outpa 28b. Tim Injury At home, farm, (Specify)  my knowledge, d kamination and/o	atient 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA attent 3 DOA atten	est Fort A ing, such as card ing, such as card ing, such as card ing.  26. Place of ther:  26. Place of ther:  27. Nursing ury at ork?  28. Yes 2 \( \text{No.} \) No in time, date and p	23e. D 23e. D 1 24a. W au ply 1   Ye 28d. Descri 28f. Locatio City or	arrest,  2  did tobacco us  Yes 2  Ass an  utopsy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entropy entr	21230  23d. Date of delive Month  Se contribute to the Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Sec	Interval Batween Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Dea
/Medical xaminer	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, In the past 12 months?  IFFEMALE: 23b. Was decedent pregnant in the past 12 months?  1	a.  Due to (or as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete to for as a complete t	pregnancy pregnancy prediction and the second sequence of):  pregnancy pregnancy prediction and the second sequence of):  2 □ ER/Outpa 28b. Tim Injury At home, farm, (Specify)  my knowledge, d kamination and/o	atient 3 DOA one of 28c. Injury M 15c. street, factory, office death occurred at the prinvestigation, in my	est Fort A ing, such as card ing, such as card ing, such as card ing.  26. Place of ther:  26. Place of ther:  27. Nursing ury at ork?  28. Yes 2 \( \text{No.} \) No in time, date and p	23e. D  23e. D  1  24a. W  au  ply  Beath (Check on  Gity or  28f. Location  City or  ace, and due to becourred at the time	id tobacco us  Yes 2  Ass an utopsy enformed?  s 2  No  Ny one)  esidence 6  be how injury  n (Street and Town, State)  the cause(s)  he, date and  29d. Date	21230  23d. Date of delive Month  Se contribute to the Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Sec	Interval Batween Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Dea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 26 2006 **Physician** 11:00AM MAMIE L. EVANS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST CENTER FOR HOSPICE TOWSON 8. Date of Birth (Month, Day, Year) 01/25/35 9. Birthplace (State or Foreign Country) N. CAROLINA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Months Days Hours 1 M 2 XF 71 Director 240-54-1763 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1XX es 2 □ No Director N/ABALTIMORE CITY MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21215 47R11 5233 CUTHBERT AVENUE USA 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itema 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 72 hours after □Yes 2**X** No Yes, Give 1 Never Married X Married Specify: BLACK Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dales: 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CASHIER CAMDEN YARDS 9TH AH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h 99 ELIZABETH SMITH JOHN MODLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth a 2119 ALLENDALE RD., BALTIMORE, MD 21215 ARTHUR SMITH / Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H.
Important: It Ital
eny Injury or oth 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE CO., MD WOODLAWN CEMETERY 5/1/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fy eral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Per Enter the disease, or complications that caused the death, shock, or heart Milure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Scuere ischemic cordiomyopath **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has 2. No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No Certification: To this After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation i efter death. I Director: Af d in by the fui 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Hospital or Attending Physician: within 24 hours e To the Funeral [

> State Registrar

filled

Medicai

31. Date filed (Month, Day,

10

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

29a, Certifier

gin( 6701 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Prini)

ins

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

N. Chales St. Balts and 21204

			1 - For State of Ma	•		it of Health a e of Death	ınd Ment		ene 0 0	6	13338
			Decedent's Name (First, Middle, Last)					ate of Death		Year	3. Time of Death
	Physici /Medic		Barbara J Ennis	•				ril		006	1600 м
	Examin		4a. Facility Name (If not institution, give street and number)	2 1	4b. City,	Town, or Location of	f Death		4c. County of	f Death	( (
			Baltimore Washington Medical		Gle	1Burnie	2411-5		Anne		ndel
	Funeral		1 N 207 E	o (In yrs. last birthd 59 Yrs		1 Year If Under 2 Days Hours	Min. (A	ate of Birth fonth, Day,	Year)	9. Birthpla	ace (State or Foreign ry)
	Director		214-56-0607				Ju	1y 1	1946	D.C	•
	yland yland		10a. State 10b. County	10c. City, Town o	r Location					10	d. Inside City Limits
	death with the Maryland me 23s or 28s-f show r must be multied at	tor	Maryland Anne Arundel	Glen	Burni	e					1 ☐ Yes 2X No
	th the	lre	10e. Street and Number		10f. Zip	Code		10	g. Citizen of W	hat Count	ry?
1	23a	al	200 Plymouth Lane Apt.	A	21	061			USA		
	er dea	nue	11. Marital Status  12. Was Decedent E Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ N	Ever in U.S.	<ol> <li>Was Deceded</li> <li>If Yes, specified</li> </ol>	dent of Hispanic Orig cify Cuban, Mexican,	jin? (Specify Y , Puerto Rican	es or No- , etc.)		- America , White, e	
36	s afte	y F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ঐN If Yes, Give Year or Dates:	0	1 ☐ Yes	20 No Specify:			Specify:	B1a	ick
PRBAR1 21215-003	n 72 hours after death with the Maryian "natural", or Neme 23a or 28a-f show edical Examiner must be multified at	Be Completed by Funeral Director	15. Decedent's Education	16a. Do	ecedent's Usu	al Occupation		1	6b. Kind of Bus	iness/Indi	ustry
25	in 72	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5-	(G	ive kind of wo e. DO NOT u	rk done during most	of working				,
212	d with	Eo	12th College (1-4013-		ay Car	e Provid	der	]	Boys &	Gir	1s Club
Ø 5	e filed al Hygi l other vant, I	3e C	17. Father's Name (First, Middle, Last)						faiden Surname	)	
<u>a</u>	should be ind Mental marked o	To E	Sam Missouri				cginia				
lan /	2 should be and Mental le marked ( raumatic av	0	19a. Informant's Name/Relationship (Type, Print)	19b. M	lailing Address	(Street and Number	ror Rural Rou	te Number,	City or Town, S	State, Zip (	Burnie,Md
$>$ $\leq$	ges 1 and 2 should be filed within to thealth and Mental Hyglene. If Item 27 ie marked other than or other traumatic avant, Ins M.		Christine Ennis(Daughter	20b. Place of Di			Date				
$\leq 5$	Pages 1 nent of H int: If Ite iry or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Aremation 3 ☐ Removal from State	Metro	crematory or c	ther place)	4-28-0		:0c. Location - 0 Baltin	-	
Raltimor			4 Donation 5 Other (Specify)	1							, 114.
Bal	permit. Depertr Importu eny Inju		21. Signature of Funeral Service Licensee		Wm Re	Address of Facility	ons Mo	ortua	ry, P.	A.	
		-	23a. Part1. Enter the disease, or complications that caused	0		est St.					L Approximate
			shock, or heart tailure. List only one cause on each lin	10.							Interval Between Onset and Death
	Physician /Medical		disease or condition a.	a consequence of):	RUBR	-AL HO	-more	HAGE			
	Examiner			t consequence on,	•						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):							
V	cuted od ransit	Examiner	that initiated events								
. 0	be executed sicien and burial-transit	EX		a consequence of):							
8760,	ate be hysici the bu	Physician/Medical	d							_	
Box 68	entific ding p	Med	IF FEMALE:							-	
Bo	ath cather	lan	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 Ectopic p				23d. Date Mon		y Day Year
9. O	he de	ysic	1 ☐ Yes 2 ☑ No 4☐ Pregnant at 9 ☐ Unknown	time or death	5 Other (sp	Deciry)					
	that i	y Ph	Part II. Other significant conditions contributing to death but	ut not resulting in th	e underlying o	ause given in Part I.	2	3e. Did tob	acco use contri	bute to the	a cause of death?
sp	uires n sign	d by						1 ☐ Ye	s 2 XNo	3 🗌 Proba	ibly 4 ∐Unknown
00	w req	iete					2	4a. Was an	24b. W	ere autop	sy findings available ipletion of cause of
Division of Vital Records,	he la e has age 2	Completed					_	autopsy	red? de	eath?	
<u>ta</u>	en: Tifical	BeC	25. Was case referred to medical			26, Place	of Death (Che		7	☐ Yes 2	- NO
S	ysici is cer direc	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatier	nt 2 ☐ ER/Outpa	atient 3 DC	Other			<del></del>	r (Specify)	)
ō	ng Ph terth	Ľ.	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injur (Month, Day	y 28b. Tim	e of 2	28c. Injury at Work?			w injury occurre		
	endir sath. or: Af he fu	atlc	Z Accident investigation		М	1   Yes 2   N	No				
Ξ̈́	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ury - At home, farm, c. (Specify)	, street, factor	y, office	28f. Lc	ocation (Str ity or Town,	eet and Numbe State)	r or Aural	Route Number,
۵	urs al										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination and/o	eath occurred or investigation	at the time, date and , in my opinion, deat	u piace, and di th occurred at t	ue to the car the time, da	use(s) and man ite and place, a	ner as sta nd due to	ited. the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier			c. License number			d. Date signed		*
			Dechu			100557	03	1	April	20,	2006
	1		30. Name and addr of person who completed cause of de BALD'MONE WASHING	ath (Item 23a) (Ty	pe, Print)				14.27		
			31. Date filed (Month, Day, Year) 32. Begistra	FTON H	10513177	CENTER	e $60$	UN B	URNIE	MI	•
	Sta Registr		ADD 2 9 2006	ar's Signature	Crest 1						

DHMH 17 Rev 1/2001

Albert William Fitzhugh, Jr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	,	Certificate o		Re	eg. No. 2001	6 13339	
Physician/ ledical Examine	1. Decedent's Name (First	il Middle,Last) illiam Fitzhugi	h Jr.		2. Date of Deaf Month April 20, 2	Day Year 006	3 Time of Death 0842 hrs	
**	4a. Facility Name (if not i	nstitution, give street and number)		4b. City, Town, or L Baltimore	ocation of Dea	th	4c. County of Dea	r/A
Funeral Director	5. Social Security Number 213-52-2		n yrs. Iast birthday) 7 Yr	If Under 1 Year Months Days	If Under 24H Hours Mi		1948 Fore	
Jaryland 28a-f show any 1 at once.	MD		oc. City, Town or Loca Owing	ation Is Mills				10d Inside City Limits 1 Yes 2 X No
the Marylands or 28a-fst or the Alexandria or 28a-fst or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexandria or the Alexa		ourt		10f. Zip Code	1117	1	0g Citizen of What Co USA	untry?
er death with , or items 23 r must be no		Married  12. Was Decedent Ev. Armed Forces?  1 X Yes 2  Divorced If Yes, Give Year	lf.	as Decedent of Hisp Yes, specify Cuban, Yes 2 X No	Mexican, Puen		14. Race - Ame White, etc.	erican Indian, 8lack,
., MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Montal Hygietne. traumatic event, the Medical Examiner must be notified at once To Re Commisted by Finneral Director		on (Specify only highest grade comple	during i	ent's Usual Occupation ost of working life.  Aufactur	on (Give kind of DO <b>N</b> OT use re		16b. Kind of Business	
e, MD 21215-0036 I and 2 should be filed within 72 should be filed within 72 item 27 is marked other than riraumatic event, the Medical To Re Comple	3 17. Father's Name (First, Albert W	illiam Fitzhug			Maria	Jones	Maiden Surname)	
re, MD 21 s 1 and 2 should of Health and Me If item 27 is ma ner traumatic ev	19a. Informant's Name/R Angelina 20a. Method of Disposition	Fitzhugh / si	ster 5 <b>(</b>	ng Address (Street Chims Co Inns estition (Name of cerr	urt Ow	Rural Route Nun	nber, City or Town, Stails MD 2	21117
imore Pages I ment of H tant: If i or other		remation 3 Removal from State Other Specify:	Garrisor	n Forest	Cem 4	/27/06	Owings	Mills MD
Balt Bernit Depart Import injury	x xray 40	/ · ·	152	240 Reis	tersto	wn Rd	Baltimore	neral Home MD 21215 Approximate Interval
/Medical - xaminer	failure list only on Immediate Cause (Final or condition resulting in			ular diseas	е			Between Onset and Death
in a second	Sequentially list condition if any, leading to immedicause. Enter Underlying (Disease or injury that in	ate Due to (or as a consequence Cause	uence of):					
executed an and al - transit	events resulting in death			27 - 22MF C	056 6/20	/o< πτ		
attending physici or use as the buri	IF FEMALE: 23b. Was decedent pregr past 12 months?  1 Yes 2 No 9	23c. If yes, outcome	of pregnancy			· · · · · · · · · · · · · · · · · · ·	23d Date of deliver	ery Day Year
i, P.O. Be tres that the de signed by the be detached f	3	t conditions contributing to death b	ut not resulting in the	underlying cause g	ven in Part I.		obacco use contribute to	to the cause of death?
Division of Vital Records, tal or Attending Physician: The law require ras after death al Director: After this certificate has been six led in by the funeral director, page 2 should be retification. To Re Commission						24a. Was autop perfo 1 🗸 Yes	prior to rmed? death?	
tal Rection: The certificate ector, page		Hospital:			of Death (Chec			
F Vit	1 Yes 2	No inpatient		•	Other Murs	38d Describe	Residence 6 Oth	er:
Division of ital or Attending Phares after death ral Director: After I lled in by the funeral	1 X Natural 5 Accident	Investigation 28e Place of Injur	y - At home, farm, str	1 Y	es 2 No			Rural Route Number, City
y filler of	29a Certifier	Could not be determined (Specify)    Could not be determined (Specify)				or Town, S	State)	
To the Hos within 24 h To the Fu completely	one) 2 Medi 29b. Signature and title of	cal Examiner: On the basis of examiner and manner stated of certifier	nation and/or investig	ation, in my opinion,		at the time, date	and place, and due to	
01	30. Name and address of	f person who completed cause of dea	ath (Item 23a)	O.C.M	Л.E.		April 22, 2006	
0	Margarita Korel			Penn Street, Ba	altimore, ME	21201		
Stat Registra	a ram C	Registrar's 8 2006	Signature	Se .				17

				For State Registrar	State of M	aryland		rtment o			nd Me	ntal Hy	/gien		post-likes	3340
				1. Decedent's Name (First, Middle, La	st)						2.	. Date of De	eath			Time of Death
		Physici /Medic		Margaret	Allen	Frank	Klin				A	Month Pol	27,	2000		1:20 PM
	3	Examin		4a. Facility Name (If not institution, giv				4b. City, To					4	c. County of D	eath	
				The Wesley	Home				Ba	Hima	ore			NA	+	
		Funeral		5. Social Security Number 6. S	Sex 7. Ag	ge (In yrs. las		If Under 1 \		If Under 2 Hours	Min.	Date of Bi	ay, Yea	r) 9.	Birthplace Country)	(State or Foreign
		Director		214-18-8018	UM 234F	93	Yrs.				Fe	bruary	22,	1903	Alabo	ama
-		/land		Usual Residence of Decedent  10a. State 10b. County	<u></u>	10c. City, T	Fown or Loc	cation							10d. li	nside City Limits
3		Maryland	৳	Maruland NA		7.	_									Yes 2 No
-		158 A	ect	Maryland NA  10e. Street and Number			Da F	timore					10a C	itizen of What	Country?	
07		T O S	급	145 W. Montgo	51				2123	2 🗚			_	USA	Country	
-		after death with the Maryla or items 23a or 28e-1 ehov	Funeral Director	11. Marital Status	12. Was Decedent		13. V				in? (Specif	v Yes or N		14. Race - A	American Ir	ndian.
21		fer d	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐	?	If	Vas Deceden Yes, specify	Cuban,	Mexican,	Puerto Ric	can, etc.)			Vhite, etc.	
(3)	ဗ္ဗ		þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2,2	No	Specify:				Specify: L	Shite	
0	Ò	72 hours "natural", dical Exe	Completed	15. Decedent's E	ducation	1	16a. Deced	lent's Usual C	Occupati	ion	of working	-	16b.	Kind of Busine	ess/Industr	у
0	2		e d	Elementary/Secondary (0-12)	College (1-4or	5+)	life. E	kind of work o	retired)	ing most	or working					
2006	7	ed wi	Co	12			ξ	sectio	-	-					ograph	nic Society
-	2	d oth	Be	17. Father's Name (First, Middle, Last,					1					en Sumame)		
27	<u>X</u>	Men	ဥ	Charles Mos								e D				
1	Maryland 21215-0036	and ie m		19a. Informant's Name/Relationship (										or Town, Sta		•
		and ealth m 27		Margaret Lee Norton	/ Niece	200 71	145 W	Mont	Son	nery	S+. !	Baltin	ore	MD Location - City	2123	0
0	Baltimore,	M ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	l cem	eterv. crem	natory or othe	ir niacei	1			1.			State
3	Ē	permit. Pages Depertment of Important: If I any Injury or once.	1 8	4 Donation 5 ☐ Other (Special	<b>(y</b> )	Anato	My 6:	fts Re	915+	ry A	pri/28	,2006	Ho	mover,	MD	
PIE	3al	permit. Deperti		21. Signature of Funeral Service Lice	nsee		22	. Name and A	Address	of Facility	Anato	omy Gi	fts i	Registry		
EXPIPLED		707 4 0												over MD		
6		Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Carse (Final	one cause on each l	ine.									Ons	oroximate erval Between set and Death
U	1	/Medical		disease or condition resulting in death)	a. PROGRE	a consequer	nce of):	52 17 15 14	1012	7	1 14/4	arce			u	CEKS
		Examiner		Commentation for the distance	b. CHE W C	OBS	TRUC	TIVE	Pu	LMON	mey	Diser	156		Y	TARS
_		7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):									
>		cuted nd ransi	Examiner	that initiated events	c.										Ц	
7	oʻ	e exe ien a urial-t		resulting in death) Last	Due to (or as	a consequer	nce of):								1	
Z	8760,	cate be executed thy sicien and the burial-transit	Ica		_ d											
-12Ax	Box 68	The law requires that the death certificate be executed as hes been signed by the ettending physicien and asge 2 should be detached for use as the burial-transl	Physician/Medical	IF FEMALE:			100									
27	ရှိ	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal de	eath 3	Ectopic preg	nancy					23d. Date of Month	delivery Day	Year
-	0	the e	SIC	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of deat	th 5□	Other (speci	ify)					Worth	Day	1021
	<u>~</u>	res that the de signed by the e i be detached f	P.	Part II. Other significant conditions	contributing to don't		an in the	adaab daa aa		in Danil		22a Did	tobasou	use contribu	to to the on	use of death?
1	Š,	ires ti signe d be c	۵	DEMENTIA - END		out not resulti	ng in the ur	idenying caus	se given	i iii Pait I.			/			4 □Unknown
17	0	w require been si should t	eted	Denter III CAD	2/1196							. ~	103			
5	ec	e 2 s	du										opsy	prior	to comple	findings available tion of cause of
7	=	The l	Completed by									1 ☐ Yes	formed? 2 X N	deat 1 □		No
MARGARE	Division of Vital Records,	ending Physicien: The laveath. or: After this certificete hes he funeral director, page 2	Be	25. Was case referred to medical examiner?	Henrital:				1 -	4		Check only				
A	of	Physi this c	ဥ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati		VOutpatien		Other	4 A Nur				6 □Other (	Specify)	
3	Ĕ	ding P. After funer	on	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	Bb. Time of Injury		. Injury a Work?			d. Describe	how in	jury occurred		
	<u>.s</u>	ittendi death. ctor: A y the fu	Cat	2 Accident investigation 3 Suicide 6 Could not be		ive. At been	- (	M		9s 2 □ N		f Lorentian	(Ctront)		- 0 - / 0	
0	<u>×</u>	or A lifter in by	Certification:	4 ☐ Homicide determined	28e. Place of In building, e	tc. (Specify)	e, rarm, stre	eet, ractory, o	пісе		281	City or To		and Number o ate)	r Hurai Hoi	ute Number,
-	۳	ospital or Al hours after of unsrel Directly filled in by	Ö	29a, Certifier 1X Certifying Pl	nueicien: To the hard	of millower	adae d et	Commission of the	the time	notation and	Colores (a)	Andrew Art	alignostico.	(a) and	man at a second	
5		HO Tury tely	dical	(Check only 2 Medical Example)	hysician: To the beat miner: On the basis of and manner si	of examination	n and/or inv	estigation, in	my opi	nion, death	h occurred	at the time	, date a	nd place, and	due to the	cause(s)
		within 2 To the comple	Me	29b. Signature and title of certifier	<u> </u>	~		29c. L	icense	number			29d. D	Date signed (N	fonth, Day,	Year)
		- 3 - ŏ		Malest &	Colus	M.D	•	7	)-1	942	5		4	カカム	20/-	
				30. Name and address of person who	complete duse of	death (Item 2	3a) (Type	Print)						E, MD	U (4)	
				ROBERT E. RO	BY M.D	22/1	W. R	0600	( A	VE-	BA	LTIN	10R	E MA	Z	1209
		Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	0 4	1 M =		<u> </u>		4 7	- 100	1		
		Regist		APR 2 8	2006	was a	1									

State of Maryland / Department of Health and Mental Hygiene () () For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** APRIL 21, TERESA FINE 10:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUAIL RUN ASSISTED LIVING Baltimore Perry Hall If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Yrs Director 212-03-6975 91 Jan.11, 1915 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or Itema 23a or 28a-f ahov vent, Ita Medical Examinat must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9111 Gardenia Road 21236 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Ď 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teller Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h Robert J. Cremen Anna O'Neill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Heelth an Important: if Item 27 Is any Injury or other trau Barbara Neukum Daughter 9111 Gardenia Road; Perry Hall, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 4/25/2006 Pikesville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licenset Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EROSCLEROTIC CARDIO VASCEILAR
as a consequence of):

DISFASE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit O. Box 68760. by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion a cause of death?

1 Yes 2 No cete has I certificate 1 Yes 2 DIO 25. Was case referred to medical examiner? Be 26. Place of ath Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: P 1 ☐ Yes 2 ☐ No 3□ DOA ursing Home 5 Residence 6 Other (Specify) this After this funeral of 28c. Injury at Work? 27. Manne 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours eft
To the Funerel DI
completely filled in 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number se of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of	Marylan	id / Depa	artment of H	lealth ai Death	nd Ment		eĥe() () (		334	12
Physici	án	Decedent's Name (First, Middle							ate of Death	Day Y	rear	3. Time of D	
/Medic	cal	RONALD JOH  4a. Facility Name (If not institution				4b. City, Town, or	Location of		oril	25, 200 4c. County of		9:50 A	<b>1.</b> ™
Exami	iei	Joseph Richey		,			imore				N/A		
Funeral Director		5. Social Security Number 262-53-7506		7. Age (In yrs. 48	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Da	te of Birth lonth, Day, 3. 23,	1957	9. Birthplac Country Mary I		Foreign
land land		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d	I. Inside City	Limits
Marylan e-f ehow	ctor	Virginia Fair	rfax		Falls	Church						1 X Yes 2	2 🗌 No
ar death with the Maryla tems 23a or 28e-f ehov at that by rediffed at	Director	10e. Street and Number				10f. Zip Code	-		10	g. Citizen of Wh	at Country	1?	
eath v	Funeral	6913 Kingwood	Drive	dent Ever in U	S 13 V	220 Vas Decedent of H		in? /Specify V	es or No-	U.S	.A. American	Indian	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "naturel", or Items 23s or 28s-f ehow other traumatic event, If a Macilial Experient fraumatic event, If a Macilial Experient fraumatic event,	by Fun	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed For	ces? 2 <b>X</b> No e	l:	Yes, specify Cuba	Specify:	Puerto Rican,	etc.)		White, etc	0.	
72 hor	eted	15. Decedent			16a. Deced	lent's Usual Occupa	ation during most o	of working	1	6b. Kind of Busii	ness/Indus	stry	
permit. Pages 1 and 2 should be filed within 72 his Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'natum any Injury or other traumatic event, if a Medical once.	Completed	Elementary/Secondary (0-12) 12 years	College (1-	-4or 5+)		kind of work done of DO NOT use retired Curity Gu		o. vog		Secu	rity		
al Hyg I other	BeC	17. Father's Name (First, Middle,	Last)		500	January Sa		's Name (First	, Middle, M	aiden Sumame)			
d Ment narked natic e	To	Charles	Finneg	an	10. 11.		Mary		Na1				
Ith and 27 io n		19a. Informant's Name/Relationsl Brenda Finnegan	hip (Type, Pnnt)	Sister	1	g Address (Street a					ate, Zip Co	ode)	
les 1 au of Hea if Item ir othe		20a. Method of Disposition  1 Burial 2 Tremation	3 Removal from S		lace of Dispos	sition (Name of natory or other plac		Date		0c. Location - Ci	ty or Town	ı, State	
t. Pag rtment rtant:		4 ☐ Donation 5 ☐ Other (S)	pecify)			nt Crema	COLY	4/27/06		Baltimo:	re, M	aryla	nd
Depa Impo any I		21. Signature of Funeral Service	Cy A AGY A AG		M	Name and Addres litchell- 500 York	Wiedef	eld Fu	neral	Home,	Inc.	1010	
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that ca only one cause on ea	sused the death	h. Do not ente	er the mode of dying	g, such as ca	ardiac or resp	iratory arres	maryian	Ap	1212 pproximate interval Between gset and De	een eath
/Medical Examiner		disease or condition resulting in death)	aN/A/	or as a consequence	uence of);	TENON OF	11CC	Pag. 1.	TUITI	0 01		en	no
*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (c	or as a conseq	uence of):		4111	MUUM	VY	1919			
te be executed /sicien and e burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
cate be execut physician and the burial-tran	dical E		d										
	Medi	IF FEMALE:	25										
The law requires that the death certify ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Fetal ant at time of d	I death 3	Ectopic pregnancy Other (specify)				23d. Date of delivery  Month Day Year			ar
w requires that been signed t should be det	ρ	Part II. Dther significant condition	2040	ath but not resi	ulting in the un	derlying cause give	en in Part I.	23		2 No 8	ute to the c	/	/
e taw re has be je 2 sho	Completed	- CHYYHA	19/5					24	a. Was an	24b. Wei	re autopsy or to compl	findings av	ailable use of
iclan: The certificate ha	e Cor	25. Was case referred to medical	30500	5						No 1	th? Yes 2		
ysiclan: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 In	patient 2 🗍	ER/Outpatient	3□ DOA Othe	ar.	of Death (Checosing Home 5		ce 6 DOther	(Specify)	4120	1111
To the Hospital or Attending Physician: whin's 24 hours after death. To the Funeral Director After this certifica completely filled in by the funeral director, p	( ' )	27. Manne of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	9	f Injury n, Day Year)	28b. Time of Injury	28c. Injury Work		28d. De		injury occurred		143/1	a
To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	Med 288. Place	of Injury - At ho g, etc. (Specify		et, factory, office		28f. Lo Cit	cation (Stre ty or Town,	et and Number ( State)	or Rural Ro	oute Numbe	∋ <i>r</i> ,
Ne Hospi	edical	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the l Exeminer: On the ba and manne	sis of examinat	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and pinion, death	place, and du occurred at the	e to the cau ne time, dat	se(s) and manne e and place, and	er as stated due to the	id. e cause(s)	
To the To the Comp	W	29b. Signature and title of certifier	Aug .	Mo		29c. License	number	1	290	d. Date signed (A	Month! Day	y, Year)	
or		30. Nanye and address of person	who completed cause	o of death (Item	23a) (Type, F	Print)	0/2	1 /	/-	1/20/	46		d
		John W. F.	TYPE 4	3/1///	nderu	DONA TO	1 1	BaHI	mor	V. MA	2/-	2/8	,
Sta Registr		31. Date filed (Month, Day, Year)	32. Re	ga trar's Signa	ture .	back	,						

RONA D FINNEGAN Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 1200 MUDREN 04 2006 /Medical Facility Name (If not institution, give street and number) 2420 Chelmsford Dr. 4c. County of Death 4b. City, Town, or Location of Death Examiner Crofton MD Anne Arundel County If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2**X**F 151 05 5181 96 Yrs. Director 2/19/10 NJUsual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If Item 27 is marked other then "naturel", or Iteme 23s or 28s-f show or other traumatic event, the Madical Examinar houst be notified at NJ 1.□Yes 2 □ No Passaic Totowa Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 87 Garfield Place 07512 USA or Iteme 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. I ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: β Specify 3 ₩ Widowed 4 Divorced Year or Dates: "naturel" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other then 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raphaele Vitale Petroniella 2 Romeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m eny Injury or other traum Valerie Humen /Daughter 2420 Chelmsford Dr Crofton MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cemetery April 15, 2006 Paterson NJ 4 ☐ Donation 5 ☐ Other (Specify) Doda2. Name and Address of Facility
Charles L. Stevens Funeral Home,
1501 East Fort Ave., Baltimore MD

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators

Operators 21. Signature of Funeral Se ice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) deteched 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has 2 X No 1 Yes : After this certifical funeral director, p Attending Physician: DAUGHTER'S 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Qther (Specify) 1 Yes 2 No HOME 2 ER/Outpatient Medical Certification: To 3□ DOA 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending 1 TYes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 ☐ Accident the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signature and title of ceptific leted cause of death (Item 23a) (Type, Print) E 31. Date filed (Month, Day, 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 2006 Richard Arnold Gibson April 8:05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center For Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **X**M 2□ F 80 223-24-0842 Aug. 25, 1925 Virginia Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2000No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Miles Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. XXYes 2 No 1943— If Yes, Give Year or Dates: 1946 1 Never Married 2 X Married 1 ☐ Yes 😥 No Specify: Specify: 3 Widowed 4 Divorced White 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 6 Machinist Machine Maunfacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Gibson Naomi Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Gibson(Wife) 303 Miles Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. April 29,2006 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signatura of Funeral Service Eluansoc 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death myocardial intercrim hours Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): tF FEMALE: 23c. tf yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? alsheimer de mentes Complications 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2.2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NoSpice 1 Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

o Records, Vital ō

Ö

00

1

GIRSON

**Physician** 

Examiner

**Funeral** 

Director

the Medical Examiner must be notified at

238

'natural'

12 should be filed within 7 and Mental Hygiene.

Pages 1 and 2 shiment of Health and tant: if Item 27 is r

permit. Page Department of Important: If any injury or once.

**Physician** 

/Medical

Examiner

physician and s the burial-transit

use as

detached

attending

ģ

certificate

After the funeral of

Director:

death.

Physician/Medical

þ

Completed

P

Certification:

29a Certifier

Baltimore, Maryland 21215-0036

Directo

þ

Completed

/Medical

within 24 hours after To the Funeral Dire completely filled

29b. Signature and title of certifier

29c. License number

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

APRIL 27 2006 D58303

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) AMON CHALLES, MO

GGOIN CHARLES ST BATTMAN GO ZIZOLY

31. Date filed (Mary Rain Year) 2006 2. Registrar's Signature

State

Registrar

For State Registrar	State of Maryland / Department of Health and Mental Hygie Amend Items 24a, 25, 26, 27, 29a, mer alprof, 585/4, 04/28/06dhb, Reg	ne
---------------------	---------------------------------------------------------------------------------------------------------------------------------	----

		,41	7	
1	3	13	1	1.7
- 1	1	U	6.0	U

ı	Physici	an	1 - For Amend Item 1. Decedent's Name (First, Middle, Last)		7 7 061	HICAGE OF	Dealit	2. Date of Death Month	Day Yeer	3. Time of Death		
	/Medic		Joan G. Gregg					Apr 9,		8:05 PM [™]		
	Examin	er	4a. Fecility Name (If not institution, give s	street and number)			Location of Death		4c. County of Dee	th		
			110 Ross Street  5. Social Security Number 6. Sex	7 Ago	(In yrs. last birthday)	Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Cecil	thplece (Stete or Foreign		
	Funeral Director		222-18-7700	M 2∑F	73 Yrs.	Months Days	Hours Min.	Yeer) C	aware			
	and * -		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	Aaryli • ho	ö	MD Cecil		E1kton					1 ☐ Yes 2√ No		
	28a-	Director	10e. Street and Number		EIRCOII	10f. Zip Code		10	og. Citizen of What C	izen of What Country?		
	3a or	Ö	110 Ross Street				21921		USA			
	me 2	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S. 13.1	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am			
0500-617	72 hours after death with the Maryland Insturel; or Heme 23e or 28e-f ehow disal Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 [X]Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	o	1 □ Yes 2 🎇 No	Specify:	rican, etc.)	Black, Whi			
5	72 hours "naturel", edical Ex	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	ation during most of work	ina	6b. Kind of Business	/Industry		
Ž	C 20	npie	Elementary/Secondary (0-12)	College (1-4or 5+	-) life.	DO NOT use retired	1)					
V	illed withir I Hygiene. other then	S	12	00	lice	ensed pra	ctical nu		healthcar	9		
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, Last)	Doan				e (First, Middle, N	,			
2	should be and Mental I marked o	2	Clarence Benjamin		105 14-2			lmeda Mc		Zie Code)		
	2 6 5 6		19a. Informant's Name/Relationship (Ty						City or Town, State,	Zip Code)		
	Hea Hea		Judith Davis/daugh	iter	20b. Place of Dispo	isition (Name of			MD 21921 20c. Location - City of	Town, State		
2	@ O = L		1 Burial 2 Cremation 3 R	emoval from State	cemetery, crer	natory or other plac	(9)					
saltimore,	permit. Pag Department Importent: It any injury o		21. Signature of Funeral Service License Ronald S	Jade, Dire	ctor Si	2. Name and Addre	ss of Facility Omy Board	655 W.	Baltimore	Street		
	20240		23a. Pal 1. Enter the dise se, or complish 1 k, or heart failure. List only or	alle			MD2120		at .	Approximate		
	Physician / Medical Examiner and physician and physician and site partial items it is the partial items it is the partial items it is the partial items it is the partial items it is the partial items it is the partial items it is the partial items it is the partial items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items items item	i Examiner	Immediat Cause (Final disease or condition resulting in death)  Societies of the condition of the cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Due to (or as a	consequence of):  consequence of):  consequence of):	nal Disc is	ease			Onset and Death		
09/89	cate b	Medicai		J								
DOX	death certiff e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the g ☐ Unknown	Fetal death 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year		
7. 5.	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions con	ntributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?		
dS	uires sign lid be	d by						1 □ Ye	s 2 No 3 P	robably 4 Unknown		
ecoras,	w require s been si should t	Completed						24a. Was ar	24b. Were a	utopsy findings available		
Ĕ	0 L 0	E C						autopsy	ned? death?	completion of cause of s 2□ No		
Vital H	icien: Th certificate rector. pag	0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2		5 2 140		
	N S F	0 8	examiner? 1  Yes 2 No	lospital:	nt 2 ER/Outpatier	nt 3 DOA Oth	00		nce 6 ☐Other (Spi	ecify)		
on of	ding After fune	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	y 28b. Time o Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred			
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, sti . (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	ural Route Number,		
	spite nours neral	edical C			f my knowledge, deat examination and/or in ted.							
	To the Within To the	Me	29b. Signature and title of certifier	600018 1		29c. Licens			29d. Date signed (Month, Day, Year)			
			30. Name and address of person who co	empleted cause of de	path (Item 23a) (Type,	Print) Suit 33	Eleton	mp 2/92	2/			
	To the Ho within 24 I To the Fu completely	Mec	29b. Signature and title of certifier	GOEN S 11	UD path (Item 23a) (Type, Work SF					29d. Date signed (Mon 322 4/18/06 PleTon MD 2/92/		

State Registrar

DHMH 17 Rev 1/2001

APR 2 8 2006 32. Hegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Yeer 6:50 AT **Physician** 6000 RUTH APRIL 25 2006 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Future Care Old Court Randallstown Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In vrs. lest birthday) **Funeral** Months Deys 1 □ M 2 🗹 F 217-82-2447 Yrs. Director 90 1, 1915 Maryland Usuel Residence of Decedent e filed within 72 hours effer death with the Meryland al Hygiene. other than "naturel", or flems 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "naturel", or items 23s or 28s-f show traumstic evant, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2008 Fernglen Way 21228 Completed by Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 戶 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 2 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 10 Own Home permit. Pages 1 and 2 should be file.
Depertment of Health and Mental Hyg.
Important: If Item 27 Is marked other any Injury or other traum-at-18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Frank Crossley Elizabeth Christhilf 19b. Maiting Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Daughter-in-Law 2008 Fernglen Way; Catonsville, Maryland 21228 Joan J. Goudy 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removal from State Woodlawn Cemetery 4/28/06 Woodlawn, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 r complications that caused he death. Do not enter the mode of dying, such es cardiac or respiratory arrest, only one cause on each line. 23a. Pert1. Enter the diseese, or shock, or heart feilure. List Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Finat disease or condition resulting in death) CORONARY DISEASE ARTERY Examiner Due to (or es a consequence ot): Be Completed by Physiclan/Medical Examiner or Attanding Physician: The law requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, igned by the ettending physician be deteched for use es the burie Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? certificate hes 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To 1 ☐ Yes 2 ☑ No this funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of : After i Injun 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours or To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner es stated 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier APRIL 25 2006 K S.RAO.TI.O 043462 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 16.5. MAD. 51133 5400 32. Registrer's Signature 31. Dete fited (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 🗎 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL Year **Physician** 5:05 PM Lois W. Gutberlet 2006 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Arno1d FutureCare - Chesapeake 7. Age (In yrs. last birthday) II Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 F Yrs 220-24-3214 86 June 14,1919 Director Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examinar must be notified at MD Anne Arundel Arnold 1 TYes 2x No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Capri Road 21012 USA Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White δ 3€3Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Tour Director 12 International Travel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis E. Spilman Freida Rempp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anne Culp Daughter 709 Capri Road; Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal Irom State permit. Page Department o Important: If any injury or once. St. Paul Cemetery 4-26-2006 4 ☐ Donation 5 ☐ Other (Specify) Violetville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RENAL FAILURE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 740 Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? L'ZHEIMER'S 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy lindings avaitable prior to completion of cause of death? CORDNARY ARTERY 2□ No 1 Yes 2 No 1 TYes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) ieral Director: After th 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 Pending 1 Tyes 2 No death. 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after of To the Funeral Direct 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the first date. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 057531 APRIL 24 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

millersville, no

Mohet Neg 8601 Veterans Huy
31. Date filed (Month, 'Day, Gar) 32. Alertrar's Signature

8 2006

06-02725	
Violet Griffin	ů,

7533

State Caryland / Department of Health and Menta /giene

in an Black machine in			
ent of Health and Menta giene		9000	1001.0
ate of Death	Reg. No	2000	13348

	1- For State Registrar	Certificate of Death						g. No 2000	13340		
Physician/ Medical Examine		ddle, Last)	oriffi	'n			2. Date of Death Month April 22, 20	Day Year	3. Time of Death 0858 hrs		
	4a. Facility Name (if not institute 1904 Hollins Street	ution, give street and number)	)	4k	o. City, Town, or Locati Baltimore	on of Death		4c. County of Deat			
Funeral Director	5. Social Security Number 215 - 74 - 1173	6. Sex 7. Ag	ge (In yrs. last birt	hday) Yrs.		Inder 24Hrs ours Min.	1-				
any	Usual Residence of Oeceden  10a State 10b. Cour		10c. City, Town	or Locatio	n		10d Inside City Limi				
Maryland 28a-f show datonce. ector	10e. Street and Number	U/A	Bo	2/4/	monu 10f. Zip Code		10	ng Citizen of What Cou	1 Ves 2 No		
th the Marylanc 23a or 28a-f sh notified at one	804 Will	pert Aven			21213			USI			
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		Married 12. Was Decedent Armed Forces 1 Yes 2 Divorced If Yes, Give Year		If Ye	Decedent of Hispanic s, specify Cuban, Mexi- res 2 No spec	can, Puerto		White, etc.	rican Indian, Black, UTan Amentin		
hours aft "natural" Examine	15. December 15. Education (S	or Dates: Specify only highest grade cor		Decedent's	s Usual Occupation (G st of working life, DO N	ive kind of v		16b. Kind of Business			
215-0036 be filed within 72 hour mal Hygiene rked other than "natuent, the Medical Exan	Elementary/Secondary (0-		5+)	1	arkonen		(F) (A) (B)	Senu	ice		
21215-0036 uld be filed within 72 Mental Hygiene marked other than c event, the Medical	Irvine	Griffin				Min	nvero	Naiden Surname)	con		
ore, MD 21. s I and 2 should by Health and Mer If item 27 is mar ner traumatic eve	Anthony K	onship (Type, Print) NURRIS/Sor	<u> </u>	770	5 Hiller	date	Rel-Ap		11/1e MD 21234		
Baltimore, MD 21215-00: permit Pages I and 2 should be filed with Department of Health and Mental Hygiene [important: If item 27 is marked other timigury or other traumatic event, the Merical properties of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the permitter of the		ition 3 Removal from St		ory or othe	on (Name of cemetery place)		Date 29/06	20c. Location - City of			
Baltimo permit Pag Department Important: injury or ot	21. Signature of Furleral Serv	vice Lichnsee		22. <b>N</b> a	me and Address of Earl	cility 105e	Funen	of Service	ne, MD .e. P.A. 021206-5105		
Physician /Medical	23a. Part I. Enter the disease failure List only one cal			ns and	acute intrac	as cardiac o ranial	r respiratory arre hemorrhag	est, shock, or heart ge associated	Approximate Interval Between Onset and Death		
, ≒xaminer	or condition resulting in death			ОСАЦІВ	e use		·				
ted Insit	if any, leading to immediate cause. Enter Underlying Cal (Disease or injury that initiate	ed C.									
8760, ifficate be executed g physician and is the burial - transit		d		7.00	. NE 055	= /1 /06	TIP.				
8760, ificate be execuging physician and state burial - transmission and should be burial - transmission but Medical	X UNPENDED			/,28a−:	f,perME,g855,	5/1/06	TT				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transitional by Physician/Medical Exampleted by Physician/Medical Exampleted	IF FEMALE: 23b. Was decedent pregnant past 12 months?	4 Pregnant a		Feta	al death 3 Ect	topic pregna	incy	23d. Date of deliver Month	ry Day Year		
box 68 the death cert the death cert by the attendir ched for use a Physicial	1 Yes 2 No 9	9 OTKIRWIT	th but not resultin		derlying cause given in	n Part I	23e Dudio	bacco use contribute to	the cause of death?		
ires that is signed by the detaction	3	Table Solid Balling to assist	ar bat not resent	9 111 1110 11	donying educe given in			2 No 3 Pro			
Records, The law require are has been signage 2 should b							24a. Was a autop: perfor	sy prior to med? death?	utopsy findings available completion of cause of		
tal Reician: Th	OF Mos spec referred to mo				26.Place of De		1 Yes 2	2 No 1 Y	es 2 No		
F Vit	1 / Yes 2 No	Hospital: 1 Inpatii		utpatient Time of In				Residence 6 Othe	er: Scene		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safered death.  Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach but the funeral director, page 2 should be detach but Dartification: To Be Commission by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desired by Desire	1 Natural 5 2 Accident	Pending Pending Fnd 4/22	Year)	1 9:00	4□ Var a		unk				
Division o spital or Attending nours after death erral Director: After filled in by the function in the filled in by the function:	3 Suicide 6 X		njury - At home, fa House	arm, street	, factory, office building	g, etc.	28f. Location (S or Town, S Baltimore	Street and Number or R tate) 1904 Holl , MD	ural Route Number, City Ins Street		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a		g Physician: To the best of m Examiner: On the basis of exa and manner stated	amination and/or i								
F × F 5	29b. Signature and title of ce		1 D		29c. License num O.C.M.E.	ber		29d Date signed (Mo	onth, Day, Year)		
		rson who completed cause of		Donn C		MD 2120	1				
Stat	a 31 Date filed (Month, Day, Ye	Assistant Medical Exar	miner 111	renn Si	reet, Baltimore, N	VID 2120					
Registra	APR 2	8 2006	her &	100							

State of Maryland / Department of Health and Mental Hygiene [ ] For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Margaret Claypoole Groesser 2:35 AM 2006 April /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore 8. Date of Birth (Month, Day, Year) July 25, 1934 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 215-34-0856 Yrs. 71 Director Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at Maryland 1 ☐ Yes 2 No Baltimore Director Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 225 Castletown Rd. 21093 iteme 23a United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or itel 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sales florist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruth Brown Edwin Ernest Claypoole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health a Important: If Item 27 ie eny injury or other treu 22 Bussing Ct. Timonium, MD Elizabeth Gambo/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gard May 1,2006 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mitchell-Wiedefeld Funeral Home, Inc. 4500 Vork Rd Raltimore, MD 21212 21. Signature of Funeral Service Licensee John O. Mitchel 6500 York Rd. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 Yes 1 Yes 2 No ours after death.

leraf Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Certification: To 1 ☐ Yes 2 ▼No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of or Attending 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of centier 29c. License number 29d. Date signed (Month, Day, Year) 2 43721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2006

27,

P.O. Box 68760,

Vital Records,

ŏ

GROESSER

MARGARET

	1	For State Registrar	State	of Ma	arylan	id / Depa <i>Cei</i>	rtmen <i>tificat</i> e	t of H	ealth ai D <i>eath</i>	nd Me	ental Hy	/gier Reg. N			13350
Physician	1	1. Decedent's Name (First, Middle Jesse L. Gra									2. Date of D Month 4-22-2		ay	Year	3. Time of Death 12:25 Р м
/Medica Examine	-	4a. Facility Name (If not institution Prince George	-				4b. City, Chev		Location of	Death				ty of Death	rge's
Funeral Director	1	5. Social Security Number 246–14–8832	6. Sex 11☑ M 2□ F	7. Ag	e (In yrs. 34	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2	Min.	B. Date of B (Month, D ept 2:	irth ay, Yea 3,19	21	COIII	place (State or Foreign ntry) ngton DC
Maryland f show		Usual Residence of Decedent  10a. State 10b. County				y, Town or Lo								1	0d. Inside City Limits  1223 Yes 2 □ No
th with the 23a or 28a	5	10e. Street and Number 1604 Potomac Av	e SE				10f. Zip					-		What Cour	•
ING 21213-UU35 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show swant, if a Mudical Examinar must be invitited at	Ž	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was D Armed 1 17 Ye If Yes, Year o	ecedent Forces? s 2 1 Give r Dates:	Nov Jan 1	1942 t	Was Deced f Yes, spec l ☐ Yes	ofy Cubai	spanic Origi n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or Nican, etc.)	0-	BI	ace - Americ ack, White, ify: Blac	etc.
6 2 d	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1 2	t grade complete	ed) e (1-4or 5	5+)	16a. Deced (Give life. U	kind of woi DO NOT us	al Occupa rk done d se retired,	ition luring most (	of working	g			Business/In	dustry
aryland 2121 2 should be filed within and Mental Hygiene. Is marked other than ", aumatic event, its Muc	2000	17. Father's Name (First, Middle, Roy Gray	Last)						18. Mother Savar		(First, Middl		n Suma	. '	
re, Maryia  1 and 2 should I Health and Ment Health and Ment Health ard Ment Health ard Ment Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Health and I Hea		19a. Informant's Name/Relations Johnnie Mae Gra			1	1604	Potom	ac A		Wash		n D	C 20	004	
Pages Pages ment of ant: If it		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)	pecify)	m State	Qu	Place of Dispo cometery, crem antico metery ₂	natory or o Nati	ther place ona1	Ma	Da ay 1,	2006	Tr	iang	le Va	own, State
Dalt permit. Departitimport sny inj once.		21 Signature of Funeral Service	mo x	ne	آح						runer shingt				
Pnysician /Medical Examiner	101	23a. Pan1. Enter the disease, or shock, or heart failure. List transdiate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due	to (or as	ne.	the proof entire the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of t							eas	e	Approximate Interval Between Onset and Death
oertilicate be executed right graysicien and use as the burial-transit	<u> </u>	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	uence of):	nce of):											
death certifice attending of for use as	ME	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐											23d. Date of delivery Month Day Yea		
		Part II. Other significant condition	Failure	o death b		alting in the un	1				1		o use con 2 🗆 No		he cause of death?
The The page	completed by	Renal Indute	sciency			ellitur toble	My	110	ng		24a. Wa auto per 1 \( \text{Yes}	opsy formed?	' I	Were auto prior to co death? 1 \( \subseteq Yes	psy findings available mptetion of cause of
大 全 電音 下	2	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Naturat 5 ☐ Pendin	Hospital: 1 28a. Da	☐ Inpatie	ıry	ER/Outpatien 28b. Time of Injury		Othe	er: 4 🗆 Nurs	sing Hom	(Check only e 5 ☐ Res 3d. Describe	idence			(y)
DIVISION OF  It or Attending Phy after death.  Officior: After this d in by the funeral of	Certification	2 Accident investig 3 Suicide 6 Could in determine	ation	ace of Injuiding, et	ury - At ho c. <i>(Specif</i>	ome, farm, str fy)	M eet, factory		/es 2□N		Bf. Location City or To	(Street own, Sta	and Nun ate)	nber or Rura	al Route Number,
	ealcal	(Check only 2 Medical one)		the best e basis o anner st	f examina	owledge, death ation and/or in	vestigation	, in my op	oinion, death	l place, ar h occurred	nd due to the	, date a	nd place	, and due to	o the cause(s)
To the within To the comple		29b. Signature and title of certifie	new	ve	2 Cm	0	اَے	) O		2			_	ed (Month,	Day, Year): 2006 MA 2018
State		30. Name and address of person  31. Date filed (Month, Day, Year)	DEVO	RE	ear's Signa	3 42 ature	33 (	Du	SENSI	Bun	y Rd,	440	77/	svi. Ke	MD 2018
Registra  DHMH 17 Rev 1/200		APR 2	8 2006	May .		K. A	park	/							

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Maryland		ent of Healt a <i>te of Dea</i>		ntal Hygie	E 0 0 0	13351
	Physicia	an	Decedent's Name (First, Middle, Last)				2	Date of Death Month	Day Year	3. Time of Death
-	/Medic	al	Cella Gallaghe  4a. Facility Name (If not institution pive str		4b. Cit	ty, Town, or Locat		PRIL.	24 2006 4c. County of Death	8:10AM
	Examin	er	SINAI HOSP			ACTIM	00=	CITY	N/	A
	Funeral Director		21.10.0201	7. Age (In yrs. las		der 1 Year If Ur	nder 24 Hrs. 8 urs Min.	Date of Birth (Month, Day, Ye	9. Birth Cou	place (State or Foreign intry) VA
3	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Ldcation					10d. Inside City Limits
875	Mary Med	tor	MD N/A	Ba	Himone	2				1 XYes 2 □ No
Se la la la la la la la la la la la la la	s 1 and 2 should be filed within 72 hours after death wiff the Marylan if Healin and Mentel Hygiens is the first 23e or 28e-1 show then 21 is marked other then "naturel", or items 23e or 28e-1 show other traumatic event, the Medical Examinar must be notified at	ai Director	10e. Street and Number 2411 Callow Au	lenue	10f. 2	Zip Code 212	17	10g.	Citizen of What Cou	•
2) 2	er dea	by Funerai		. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Dec	pedent of Hispanic pecify Cuban, Me	c Origin? (Special cican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
Galla-	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ Vo If Yes, Give Year or Dates:	1 ☐ Yes	2 No Spe	ecify:		Specify: B	ack
2 kg	72 hou	sted	15. Decedent's Educal (Specify only highest grade of	tion	16a. Decedent's Us	sual Occupation	most of working	161	b. Kind of Business/I	ndustry
$\angle \overline{2}$	within ne. hen "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)			Donne	estic
<b>42</b> ≥	filed Hygie Dther I	မ ငိ	17. Father's Name (First, Middle, Last)	NIA	TION	iemake		First, Middle, Mai		
∩UUU Maryland	should be nd Mentel marked o	To Be	Joseph Taylor  19a. Informant's Name/R to ship (Type	Print)	10h Mailing Addre			Illians	ity or Town, State, Z	in Code)
	alth an 27 le	H	Irene G. Downing	4 1	2411 Ca	1.4	_	Baltin		21217
1+1/2 imore,	permit. Pages 1 and Depertment of Health Important: If Item 27 eny injury or other tr ance.		20a. Method of Disposition  1 Preparation 2 Cremation 3 Pen	20b. Pla	ce of Disposition (N	lame of r other place)	Dat		c. Location - City or T	own, State
S. E.	permit. Pages Depertment of Important: If it eny injury or o		4 □Donation 5 □ Other (Specify)	A	trbutus		04.26	06 B	baltimore	MD
Bal	Depertit. Depertit Importit eny inj		21. Signature of Funeral Service Licensee	Sio	22. Name Vaug W 4905	and Address of F n C. Gree York Ro	ene Fun	eral Se Hmore	MD 2121	2
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death, cause on each line.		ode of dying, suc	h as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	cardi	ac di	1 <rh< th=""><th>ythan.</th><th>ia</th><th></th><th>1 hour</th></rh<>	ythan.	ia		1 hour
	Examiner			Due to (or as, a conseque	to me	With				
	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):	10-	<u></u>	·		
	ecute and t-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseque	rtens	ion				
68760,	ficate be executed physicien and is the burial-transit	alE		200 10 (01 00 200130400	inos or).					
	* O 6	ledical	d.							
Вох	eath certii ettending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnand 1 Live birth 2 Fetal d	leath 3 Ectopic	pregnancy			23d. Date of delin	,
	the the	Physician/M	1 Yes 2 No	4☐ Pregnant at time of dea 9☐ Unknown	th 5 Other (	(specify)			Month	Day Year
, P.O	s thet the ned by e detac		Part II. Other significant conditions contri			g cause given in P	Part I.	23e. Did tobac	co use contribute to	the cause of death?
ords	w requires thet been signed to should be deta	Completed by	renalins	utticien	Cy			1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Denknown
ecc	~ D 76	npie	······································					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	ician: The law certificete has rector, page 2 s							performed 1 ☐ Yes 2 ☑		2 🗆 No
Χ	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ⚠ es 2 ☐ No	spital: 1   Inpatient 2	R/Outpatient 3 ☐ [	1 011		Check only one)	e 6 □Other (Spec	
٥	ding Phys th. After this funeral di		27. Manner of Death 1 □ Natural 5 □ Pending		28b. Time of Injury	28c. Injury at Work?		d. Describe how		пу)
sio	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be		М	1 🗆 Yes				
Division of Vital Records,	al or At efter d Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto	ory, office	28	f. Location (Stree City or Town, S	it and Number or Ru State)	ral Route Number,
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examina	r: On the best of my knowledge.  To the basis of examination and manner stated.	ledge, death occurre on and/or investigation	ed at the time, dat on, in my opinion,	te and place, and death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	`	2	29c. License num	ber	29d.	Date signed (Month	, Day, Year)
	05		Welliam (,	Jaquis, M	10	0579	129	A	PRIL "	24, 2006
F	)		30. Name and address of person who com	V a	23a) (Type, Print)					
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	VUI-C					
	Registr		APR 2 8 2006	Marie 18	E STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR					

Decedent's Name (First, Middle, Last)     Mary Virginia     A. Facility Name (If not institution, give s	TT .							
	77 .				2. Date of Dea Month		Vand	3. Time of Death
4a. Facility Name (If not institution, give s	Hinton					24, 20	Year 06	7:40 AM
	treet and number)		4b. City, Town, o	or Location of Deat	h	4c. Count	y of Death	
Suburban Hospita	a1		Bethese	da		Mo	ntgom	erv
Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs		1		place (State or Fore htry)
359-20-3526	M 2 F 81	Yrs.	Months Days	Hours Min.	(Month, Day March 4			Jersev
Usual Residence of Decedent					1-2	, 1,15	11011	ocisey
10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	10d. Inside City Lim
DC none	W.	ashinot	ton. DC					1 ☐ Yes 2 ☐ I
10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
471 H Street NW			2000	7.1		IJςΛ		
	2. Was Decedent Ever in U	.S. 13. V			pecify Yes or No-		ce - Americ	can Indian.
TTT Maria Grands	Armed Forces?	li li	Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)			
	If Yes, Give A	1	I□Yes 2ŽNo	Specify:		Spec	fy: Whi	te
		162 Doors	tont's Usual Occur	nation	1	16h Kind of		
		(Give	kind of work done	during most of wo	rking	160. Kind of I	ousiness/in	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)			ru)		0		
	4	поп	nemaker		4000 1 1 1 1 1 1 1			
							me)	
John David Stodder				Helen	Adelia W	atson		
19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	ig Address (Street	t and Number or Ri	ural Route Numbe	r, City or Town	n, State, Zip	Code)
Page W.T. Stodder	(Brother)	50	W. Schil	ller St.	Chicago	, IL	50610	
20a. Method of Disposition		Place of Dispo	sition (Name of	ocal I	Date	20c. Location	- City or To	own, State
	emoval from State	-		1	/26/06	Alevana	dria	V/ A
					720700	Alexand	ıı ıa,	VA
21. Signature of the Estates	Openet	() Cr	emation	Society	of Illin	ois		
The work of the	rever	73	6 W. Add	lison St.	Chicago	, IL 60	<del>613</del>	Approximate
disease or condition resulting in death)	Due to (or as a conseq	uence of):				11.0		
IF FEMALE:								
23b. Was decedent pregnant in the past 12 younths? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta	al death 3		<b>y</b>			23d. Date of delivery Month Day	
Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to	bacco use co	ntribute to t	he cause of death?
Acute Renal Failur	е				101	es 2 🗆 No	3 Prol	oably 4 XiUnkno
					04-146-			
					autop	sy	prior to co	opsy findings availal omptetion of cause of
							1 Yes	2□ No
25. Was case referred to medical				26. Place of De	ath Check only o	ne)		
1 ☐ Yes 2 No	ospital: 1X Inpatient 2	ER/Outpatien	t 3 DOA Ot	her: 4 Nursing I	Home 5 ☐ Resid	lence 6 🗆 O	her (Specia	fy)
27. Manner of Death	28a. Date of Injury		28c. Inju	iry at	28d. Describe h	ow injury occu	irred	
	(Month, Day 16a)	injury			1			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At h building, etc. (Specif	ome, farm, str fy)	eet, factory, office	ı	28f. Location (S City or Tow	Street and Number or Rural Route Number, wn, State)		
29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and ridate and place	anner as s , and due t	stated. o the cause(s)
29b. Signature and title of certifier	in a		29c. Licen	se number		29d. Date sign	ed (Month,	Day, Year)
(Au	with.		D378	391		April 2	5. 20	006
20 Name and address of account of	moleted course of death //t	m 22a) /T		-		-P 2	20	
			*	409 Pos	kwilla '	ND SUGE	2	
	10e. Street and Number  471 H Street NW  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  John David Stodder  19a. Informant's Name/Relationship (Type Page W.T. Stodder  20a. Method of Disposition 1 Burial 2 Ceremation 3 Relationship (Type Page W.T. Stodder)  21. Signature of Funeral Service Licenses  23a Part 1. Enter the disease of Compile Shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading in death)  Sequentially list conditions, if any, leading in death)  Sequentially list conditions, if any, leading in death)  Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 ynonths? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions conducted Renal Failure  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physical Could not be determined  29b. Signature and title of certifier  29b. Signature and title of certifier	10. Street and Number   471 H Street NW   11. Marital Status   12. Was Decedent Ever in U Armed Forces?   1   Yes 2   No   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:   1   Yes 6, Give A   Year or Dates:	10. Sireet and Number   471 H Street NW   11. Marital Status   12. Was Decedent Ever in U.S.   13. Marital Status   12. Was Decedent Ever in U.S.   13. Marital Status   15. Decedent Ever in U.S.   14. Marital Status   15. Decedent Ever in U.S.   16. Decedent Ever in U.S.   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Marital Status   18. Ma	106. Street and Number  471 H Street NW  11. Martal Status  12. Was Decadent Ever in U.S. Armold Forces?  11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11. Yes 2 CHN   11.	10. Street and Number  471 H Street NW  11. Mariat Status  1 New Married 2 Married  3 Widowed 4 Dovorced  12. Was Decedent Ever in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 11. Was Decedent Hybrid in U.S. 12. Name And Address (Street and Mumber or River Hybrid in U.S. 12. Name and Address (Street and Mumber or River Hybrid in U.S. 12. Name and Address of Facility 12. Name and Address of Facility 12. Name and Address of Facility 12. Spantary in U.S. 12. Name and Address of Facility 12. Spantary in U.S. 12. Name and Address of Facility 12. Name and Address of Facility 12. Name and Address of Pacility in U.S. 12. Name and Address of Pacility in U.S. 12. Name and Address of Pacility in U.S. 12. Name and Address of Pacility in U.S. 12. Was Decedent Hybrid in U.S. 12. Name and Address of Pacility in Pacility in U.S. 12. Name and Address of Pacility in Pacility in U.S. 12. Name and Address of Pacility in Pacility in U.S. 12. Name and Address of Pacility in Pacility in U.S. 12. Leans on	10. Street and Number 471 H Street NW 11. Marital Status 12. Was Decedent Ever in U.S. 11   Never Married 2   Married   12   Was Decedent Ever in U.S. 11   Never Married 2   Married   12   Was Decedent Ever in U.S. 11   Never Married 2   Married   12   Was Decedent Ever in U.S. 12   New Decedent of Hispanic Crigor? (Speedy Yes or No-Married Process*) 13   Was Decedent of Hispanic Crigor? (Speedy Yes or No-Married Process*) 14   Yes 2 (\$\text{No. Speedy}) 15   Decedent Sequential Process*   12   Yes Sequential Process*   13   Yes Decedent of Hispanic Crigor? (Speedy Anne) 15   Decedent Status   14   Yes 2 (\$\text{No. Speedy}) 16   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Decedent Status   15   Deced	10. Street and Number  471 H Street NW  10. 2p Code  20001  USA  Amed Forces?  10. 4p Code  20001  USA  Amed Forces?  10. 4p Code  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Status  11. Martial Sta	10s. Street and Number  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Code  17f. Tep Cod

Please Ty	ype or Prii	nt in Black In	delible l	lnk. Ensu	re All (	Copies Ar	e Legibl	
For	State of M	aryland / Depa	artment (	of Health a	ind Mei	ntal Hygier	ne () ()	3353
1 - State Registrar		Cei	rtificate	of Death		Reg.	No.	
1. Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day Ye	3. Time of Death
Georgetta Den	ise	На	rdin		A	pril 20,		10:00 AM
4a. Facility Name (If not institution, give st	treet and number)		1	wn, or Location of	f Death		4c. County of I	Death
St. Thomas More Nu	rsing &	Rehab	Hya	ttsville			Prince	George's
5. Social Security Number 6. Sex	7. Ag	je (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.			Date of Birth	9.	Birthplace (State or Foreign Country)
211-40-9041	M 2K)F	77 Yrs.	Months [	Days Hours	Min. F	eb. 22,	1929 S	outh Carolina
Usual Residence of Decedent								
10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
Maryland Prince Ge	orge's	Fort Was	hingto	n				1 ☐ Yes 2 📉 No
10e. Street and Number			10f. Zip C	ode		10g.	Citizen of Wha	it Country?
11316 Fort Washingt	on Road		20	744		U.	S.A.	
11. Marital Status	2. Was Decedent Armed Forces?		Was Deceder	nt of Hispanic Orig	in? (Specif	y Yes or No-		American Indian, White, etc.
1 X Never Married 2 ☐ Married	1 ☐ Yes 2 📉	No	1∐ Yes 2∑		, 1 4010 1110	an, otc./		vinte, etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		TLI Yes 21	No Specify:			Specify:	Black
15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual (	Occupation done during most	of working	16b	. Kind of Busin	ess/Industry
Elementary/Secondary (0·12)	College (1-4or	life.	DO NOT use	retired)	o, working			
	1	Nurs	ing As	sistant		Me	rcy Hos	spital
17. Father's Name (First, Middle, Last)				18. Mother	r's Name (F	First, Middle, Maid	fen Sumame)	
Sylvester Hardin,	Sr.			Maud	Wils	on Hardi	n	
19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Maili	ng Address (S	Street and Numbe	r or Rural F	Route Number, Ci	y or Town, Sta	ite, Zip Code)
Sandra Duckett	(Daughtei	304	Brinto	n Ave.,	#2 Tr	afford,	PA 1508	35
20a. Method of Disposition		20b. Place of Dispo	osition (Name	of er place)	Date	e 20c	Location - Cit	y or Town, State
1 🔀 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Round Hi	11 Cem	etery 4		6 Eli	zabeth	, PA
21. Signature of Funeral Service License	Min		Robert	Address of Facility A. Wate tchell A	rs Fu	neral Ho Clairton	me • PA 15	5025
23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that cause	d the death. Do not en						Approximate Interval Between
Immediate Cause (Final	e cause on each		ardia	100		Onset and Death		
disease or condition resulting in death)	Due to (or as			ul Infa				minutes
	200 10 (01 23	Dial	oetes			Years		
Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):						
Cause (Disease or injury								
that initiated events c. resulting in death) Last	Due to (or as	a consequence of):						
d.								
IF FEMALE:	3c. If yes, outcome	of pregnancy					23d. Date of	f delivery
in the past 12 months?		2 Fetal death 3	Ectopic preg				Month	- 1
1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknown	it time of death 3	_ Other (spec	.uy/				
Part II. Other significant conditions conf	tributing to death t	out not resulting in the u	ınderiving cau	ise given in Part I.		23e. Did tobaco	co use contribu	ite to the cause of death?
Hypertension						1 ☐ Yes	2∐No 3[	Probably 4 Nnknown
ESRD on di						24a. Was an	24b Wo	ro autonov findinge available
	7.5.10				_	autopsy performed	? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
25. Was case referred to medical examiner?				26. Place	of Death (	Check only one)		
1 ☐ Yes 2 No	ospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatie	nt 3□ DOA	Other: 4 Nu	rsing Home	5 Residence	6 □Other	(Specify)
27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Inji (Month, Da	ury 28b. Time of Injury	of 280	d. Describe how i				
3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of In building, e	reet, factory,	28f. Location (Street and Number or Rural Route Number, City or Town, State)					

within 24 hours after death. To the Funeral Director: After this certificete hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier

**Physician** /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event. Ite Medical Examinat must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

State Registrar

WASHINGTON D.C., 20010 STREET N.W. IRVING 31. Date filed (Month, Day, Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier R. Sundhum

M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DOO 61614

29d. Date signed (Month, Day, Year)

4/21/06

			1 - For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	artment tificate	of H	ealth a Death	ınd M	lental Hygi	ene () ()	6	13354		
	Blooder	- 1	1. Decedent's Name (First, Middle, I	.ast)							2. Date of Death Month	Day	Year	3. Time of Death		
	Physici /Medic		Katherine Deal				ŀ	la11	er		April 2	23, 200	6	10:40 A ^M		
	Examin	_	4a. Fecility Name (If not institution, g		ber)		•		Location o	f Death	4c. County of Deeth					
			Rockville Nursin	g Home				ckvi				Montg	gome	ry		
	Funeral Director		5. Social Security Number 214-32-9413	Sex 7 1 ☐ M 2 💆 F	'. Age (In yrs. Ia 92	est birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Aug. 7,	^{Year)} 1913	Cou	place (State or Foreign ntry) ginia		
g	> "		Usual Residence of Decedent  10a. State 10b. County		100 City	. Town or Lo	ention							10d. Inside City Limits		
aryla	Sho a	<u>_</u>												1 ☐ Yes 2 ☐ No		
E P	8a-f	Sc	MD Montgo	mery	Koci	kville			-		145	0.00	/h G			
VICT II	De D	ä	10e. Street and Number	,									g. Citizen of What Country?			
be filed within 72 hours after death with the Maryland half lygiene. Ital Hygiene. do other than 'natural', or Itams 23s or 28s-f show event, the Medical Examiner must be notified.	Ta l	303 Adclare Roa					850		1-0 /0-		USA	Amori	can Indian,			
	Funeral Director	11. Marital Status	12. Was Deced	es?	5. 13.	Yas Decede Yes, speci	fy Cuba	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		k, White,				
rs aft	ò	by F	1 Never Married 2 Married  3 Widowed 4 Divorced	If Yes, Give	)		1 ☐ Yes 2 ☐ No Specify:					Specify.	Ta	Thite		
3 0	filed within 72 hours after Hygiene. Ther than "natural", or Ita ent, the Medical Examina	ed	15. Decedent's			16a. Dece	ent's Usual	Occupa	ition		1	6b. Kind of Bu				
in 72 in 72	Completed	(Specify only highest of	rade completed)	45-)	(Give life.	(Give kind of work done during most of working life. DO NOT use retired)							•			
d withi glene.		E O	Elementary/Secondary (0-12) 7	College (1-	40f 5+)	Hom	emake	r				Own Ho	me			
ile ile	othe ent,	BeC	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle, M	laiden Sumam	θ)			
d 2 should be file	is marked o	To B	John M. Deal						Bor	nnie	Gera For	rd				
should	l Health and Menitem 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,											o Code)		
	事だれ		Joyce Mullineau	x - Daugh	iter	115	Ro11:	ing	Road	Gai	ithersbu	rg, MD	208	377		
<b>–</b>	item 2 item 2 other		20a. Method of Disposition		20b. Pla	ace of Dispo metery, crer	sition (Name	e of	9)			Oc. Location -	City or To	own, State		
Pages	ent o ht: If y or		N☐Burial 2 ☐Cremation 3 4 ☐Donation 5 ☐Other (Spe		iaib	est la			- 1	4-27	-06	Richmon	. T	rA.		
nit.	Department of I Important: If it any injury or o once.	1 19	21. Signature of Funeral Service Lit		- 0		. Name and		Ly			TEIIIIOII	U V	A		
D ed	Dep Imp		Muen he	2 brot	00						Co., Inc		20			
			23a. Pan1. Enter the disease, or co shock or heart failure. List on	mplications that ca	used the death.						chmond, I		30	Approximate Interval Between		
be executed (II)	Medical wad wad water in the burial-transil	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I am a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hypertensive Heart Disease  Due to (or as a consequence of):  b. Diabetes Mellitus  Due to (or as a consequence of):  c. Dementia  Due to (or as a consequence of):  d.												
the death certificate	tending por use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		th 2 Fetal int at time of de	death 3	Ectopic pre					23d. Date Mor		ery Day Year		
o, r	gned b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Wunder					
The law	has be	Completed									24a. Was an autopsy perform	ped? d		opsy findings available ompletion of cause of 2 No		
	s certificate director, pag	Be 0	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one					
	direc	To E	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ In	patient 2 E	ER/Outpatier	t 3 DO	A Othe	or: 4 💢 Nu	rsing Ho	me 5 ☐ Reside	nce 6 Othe	er (Speci	fy)		
ing .	Afte une		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury	28 M	Sc. Injury Work	at ? /es 2 🗆 t		28d. Describe ho	w injury occurre	ed			
5 0	i Sir	Certification:	3 Suicide 6 Could not determine	200. Flace	of Injury - At hor g, etc. (Specify)	me, farm, str	eet, factory,	office			28f. Location (Str City or Town,		er or Rur	al Route Number,		
L Hospital	24 hours Funera etely fille	Medical C		Physician: To the t eminer: On the ba- and manne	sis of examinati											
0	within To th compl	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date signed	(Month,	Day, Year)		
	1		Property	U.	Sc 86	NU	r	SOOA	7330			April 2	5. 2	006		
n	N.		30. Name and address of person wh			-		2004	1330		1 E	Thirt 7	J, 2			
1	) •		Thomas Joseph,		Edmons			Rock	ville	. МГ	20850					
	Sta	ite	31. Date filed (Month, Day, Year)		gistrar's Signat											
	Registi		ADD 2 8 2	nns Me	11	Ana	ells.									

DHMH 17 Rev 1/2001

06-02758 Mystery T Hillian

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

stery i riilliai		1- For State  Certificate of Dealerstare  Registrar			. No. 2006	13355
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last)  Mystery Thoma Hillian		2. Date of Death Month I April 23, 20	Day Year	3 Time of Death 1057 hrs
·			y, Town, or Location of Death		4c. County of Death	
			restville		Prince George	
Funeral Director			nths Days Hours Min		(MM/DD/YYYY) 9 Bird Foreig 3, 1997 Con	
/ any		10a. State 10b. County 10c, City, Town or Location				10d. Inside City Limits
/land -f show	ţ	MD Prince George Capitol Heigh	lts Zip Code	Lan	031	1 Yes 2 No
vith the Maryland 23a or 28a-f show a notified at once.	Director	3733 Donell Drive Apt. 203	20747	109	Citizen of What Cour	nry?
MOTE, MD 21215-0036  Pages 1 and 2 should be filled within 72 hours after death with the Maryland er of Flealth and Mendal Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, spe	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
after de al", or	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced of Yes, Give Year or Dates:	2 X No specify:		Specify: B	lack
hours :			ual Occupation (Give kind of v working life. DO NOT use reti		16b. Kind of Business/I	ndustry
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene artition 27 is marked other than "natural"; or other transparic event, the Medical Examiner	Completed	3 Student			Educatio	n
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
212 ould be Menta marke	To Be	Antonio Hillian  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Addre	ess (Street and Number or I	D. Powe		Zip Code)
MD and 2 sh alth and 2 in 27 is		Eloise Vicky Powe (Grandmother) 346 Hu  20a. Method of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition (Power of Disposition	ger St. Chera		520 20c Location - City or	Town State
nore, ages 1 a nt of He t: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other pla	ice)			TOWIT, State
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other transmatic event, the Med		4 Donation 5 Other Specify: Foundry Hill 21. Signature of Funeral Service-Licensee 22. Name a	and Address of Facility		Cheraw, SC	
		236. Part I. Enter the disease, or complications that caused the death. Do not enter the mode	s Funeral Homershaw Street	cheraw,	SC 29520	Approximate Interval
Physician /Medical	4	it, shock, of fleat	Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Blunt and Sharp Force Injuries  Due to (or as a consequence of):				
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):				
760, Toate be executed physician and the burial - transit		d				
60, ate be evolusions obysician	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d Date of delivery	
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	/sician//	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fedal dea	444	ancy	,	yay Year
Box 68 e death certif the attending ed for use as	Physic	1 Yes 2 No 9 Unknown Unknown Unknown Unknown	ipecify)			
P.O. Bc	by P	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.		acco use contribute to  2 ✓ No 3 Prob	
ds, I equires een sig ould be				24a. Was an	24b. Were au	topsy findings available
ecor he law i ite has b	Completed			autopsy perform	ned? death?	ompletion of cause of
	Be C	25. Was case referred to medical examiner?	26 Place of Death (Check	only one)		
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	잍	1 Yes 2 No Inpatient 2 ER/Outpatient 3	00A Other Nursir		esidence 6  Other	: Scene
	ation	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: Day, Year) 4 Apr 23, 2006 28b. Time of Injury FOUND: Apr 23, 2006 1030 hrs	1 Yes 2 ✔ No	Subject assa		
Division of Vital Records, within 24 hours after demining Physician: The law required to the Funcial or Attending Physician: The law required to the Funeral Birector; After this certificate has been significately filled in by the funeral director, page 2 should be	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office building, etc.	or Town, Sta	reet and Number or Ru ite)	
Hospita 4 hours Funeral ely fille	ပ	4 Homicide determined (Specify) Residence  29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at	the time, date and place, and		Drive, District H	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
	Σ	29b Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Moi April 24, 2006	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	J.J.IVI. E.			
t		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111	Penn Street, Baltimo	re, MD 21201		
S Regis	tate trar	for 15th 15th 15th 15th 15th 15th 15th 15th	0			

06-02788 James Hopkins

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	778	100	13	100			15.150	
	100	11	0	1-	-		Sund	
Rea. No.	Line	63	10	12	E.	 w	5	-
tea. No.								

		1- For State Registrar			Certific	ate of	Death			Reg.	No.	UO	10000	
Physicia	:1117	Decedent's Name (First, Middle)								ate of Death onth D	ay Yea		3. Time of Death	
Medical Exami	ner	James Edward Hop							Ap	ril 24, 200	06		2049 hrs	
		4a Facility Name (if not institution		nd number)		41	City, Town, or L	ocation of D	eath		4c. County o	f Death		
		Johns Hopkins Hospit		Y			Baltimore	7			<u> </u>			
Funeral	1	5. Social Security Number	6. Sex		In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 Hours	Min 8. I	Date of Birth (	MM/DD/YYYY	Foreign		
Director		220-86-0263	1 X M 2	F	39	Yrs.	L	, louis		10-25-1966			intry) MD	
*	- [	Usual Residence of Decedent		1.0									467111111111111111111111111111111111111	
w an		10a. State 10b. County		11	0c. City, Town	or Locatio							10d. Inside City Limits	
and sho	٥	MD	NA NA				Baltimon	re					1 X Yes 2 No	
Maryland <b>28a-f</b> show any <u>d at once.</u>	Director	10e. Street and Number					10f. Zip Code			10g.	. Citizen of Wh	at Count	rry?	
the 3a or		1510 Mosher Street				_	21217				USA			
72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho af Examiner must be notified at once.	Funeral	11. Marital Status		s Decedent E	ver in U.S.		Decedent of Hisp s, specify Cuban,				14. Race White		an Indian, 8lack,	
death or ite	Š	1 X Never Married 2 M	arrieu		No	1110.	s, specily Gubari,	Mexicall, Fu	dello Mical	i, etc.)	VVIIILE			
after al". c	ğ	3 Widowed 4 Div	orced If Yes, Gir or Dates:	ve Year			Yes 2X No specify					Specify: Black		
2 hours afte "natural". Examiner		15. Decedent's Education (Spe					s Usual Occupation st of working life.			one 1	6b. Kind of Bu	siness/In	dustry	
	Completed	Elementary/Secondary (0-12)	Colle	ege (1-4 or 5+	)									
Ned in	Ĕ	11				Lá	aborer				Constru		ı	
5-00; Tled with Hygiene d other t		17. Father's Name (First, Middle	Last)				1				iden Surname)			
21215-0036 uld be filed within 72 hours after Mental Hygiene marked other than "natural", c event, the Medical Examiner	o Be	Melvin Hopkins  19a Informant's Name/Relations	U.S. (Torrest Dalle)		140		A -1-1 (O)			Lyles		·	7.0.1	
	۲	19a Informant's Name/Relationship (Type, Print )  Melvin Hopkins/ Father  19b Mailing Address (Street and 1510 mosher Street									i, State,	Zip Code)		
Z dalth alth aum	-	20a Method of Disposition	tner				ion (Name of cem		Date		20c. Location -	City or T	Lown State	
es 1 a of He If its		1 X 8urial 2 Cremation 3 Removal from State crematory or other place)												
Page Page ment lant:		4 Donation 5 Other Specify: King Memorial Park 05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility							)5 <b>-</b> 01 <b>-</b> 0	01-06 Randallstown, MD				
Baltimore, permit Pages I at Department of He. Important: If ite			Licensee						(00.1	. ~'1		n 1.		
		Wylie Funeral Home 638 N. Gilmor Street Baltimor  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approx												
Physician Waling		23a. Part I. Enter the disease, or failure. List only one cause		that caused th	e death. Do no	ot enter the	e mode of dying, s	such as cardi	liac or resp	iratory arrest	, shock, or hea	ırt	Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease		n intox									Death	
i		or condition resulting in death)	Due to (o	r as a conseq	uence of):									
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a conseq	uence of):							$\overline{}$		
	<u>اةِ</u> ا	cause. Enter Underlying Cause		45 4 6511364	401100 017									
- =	Examiner	events resulting in death) Last Due to (or as a consequence of):												
8760, tifficate be executed as physician and as the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - transite the burial - trans			d		"oo o=	00 C	15. 05	= = /4 /0						
760, cate be execut physician and the burial - tran	n/Medical	X UNPENDED	AMENI	DED iter	n#23a,2/	,28a-i	perME,g85,	5,5/1/0	)6 TT					
8760, tificate bong physicas the bung	N N	IF FEMALE: 23b. Was decedent pregnant in the			of pregnancy						23d. Date of			
68 certif nding	ä	past 12 months?		Live birth Pregnant at tir		Feta		Ectopic pre	regnancy		Month	Da	ay <b>Y</b> ear	
Box e death o the atten ed for us	Physicia	1 Yes 2 No 9 Un		Unknown		Oth	er (Specify)				ŀ			
;, P.O. Box 68' ires that the death certification is signed by the attending the detached for use as:	F	Part II. Other significant condit	ions contribu	ting to death b	out not resultin	g in the un	derlying cause gi	ven in Part I.	i. :	23e. Did toba	cco use contri	bute to the	he cause of death?	
P.O. es that the rigned by the detac	þ									1 Yes	2 No 3	Proba	ably 4 🗸 Unknown	
ords,  ** require  s been si  should t	tec							-	— h	24a. Was an	24b. V	Vere autr	opsy findings available	
COF law r has b	힐								- 1	autopsy performe		rior to co leath?	ompletion of cause of	
tal Re( rian: The certificate	Completed								1	✔ Yes 2		✓ Yes	s 2 No	
tal cian: certif ector,	Be	25. Was case referred to medica examiner?	Hospital:					of Death (Ch						
hysisi al dir	P.	1 V Yes 2 No		Inpatient	2 <b>V</b> ER/O		0 0011	, L.J.	lursing Hor		esidence 6	Other:		
ing Physi Jang Physi After this funeral dii		27. Manner of Death  1 Natural 5 Pen		Date of Injury (Month, Day,Yea	ır)	Time of Inj		y at Work?		Describe how	w injury occurre	∌d		
SiOr strend death ctor: y the	äţį	- Fell	stigation LT1	-	3006   Fno		111	es 2 X No	uir					
Division of Vital Records, pital or Attending Physician: The law require ours after death erral Director: After this certificate has been si filled in by the funeral director, page 2 should the in by the funeral director,	Certification		id not be				, factory, office bu	uilding, etc.	28f. I	Location (Stre or Town, Stat	eet and Number te) 807 MC	r or Rur Kim (	al Route Number, City	
Division Hospital or Attene 24 hours after death Funeral Director: tely filled in by the	Ö	4 Homicide	rmined (Sp	ecify)	Found in	n house	9		Bal	timore,	MD			
	g						ed at the time, dat							
To the Hos within 24 h To the Fun	Medica	2 🗸	and mar	ner stated	mation and/of I	vesuga((			rou at tile					
	Σ	29b. Signature and title of certific					29c. License				29d Date signe		th, Day, Year)	
		iaral t	talle	av			O.C.N	/I. <b>∟</b> .		4	April 25, 20	Ub		
15		30. Name and address of person				_		- 1-	1001		•			
0 1			sistant Med	Code:		Penn S	treet, Baltimo	ore, MD 2	1201					
	tate	31. Date filed (Month, Day, Year)	2006	32 Registrar's	Signature	2334	K)							
Regis	trar	APR 2 8	7000	SAL SECTION	- 6	1								

			1 - For Amend Item 2	State of Ma Ob per FH	ryland ,G854,	Depa	artment of 1 28/06dhb	lealth Death	and M	ental Hy	giene Reg. No.	06	1335	57	
			Decedent's Name (First, Middle, Last)							2. Date of De	ath		3. Time of	Death	
	Physici /Medic		John W +	tamilt	ton	7	56			Month	2/11	Year 2006	6-12	PM	
	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, o	r Location	of Death		4c. Co	unty of Death			
			Howard County Ger	neral Hosp	pital			mbia			Howard				
	Funeral		5. Social Security Number 6. Sex 408-01-4150	7. Age	(In yrs. last	birthday) 4 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	of Birth th, Day, Year) Country)  9. Birthplace (St			r Foreign	
	Director		Usual Residence of Decedent			4 frs.		ys Hours Min. June 6, 1921					essee		
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation					1	0d. Inside Cit	y Limits	
	Man a-f-sh	ţċ	Maryland Howard		Co1	umbia	a					j	1 🗌 Yes	2 🔀 No	
	or 28	Director	10e. Street and Number				10f. Zip Code				•	of What Cour	try?		
	23a	le l	10548 Rivulet Ro	)W			21	044			U.	U.S.A.			
	tems	by Funeral	The Marian Character	12. Was Decedent E Armed Forces?		13.	Was Decedent of H If Yes, specify Cub	lispanic Or an, Mexica	rigin? (Spe in, Puerto F	city Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,			
36	rs afte	γF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ N If Yes, Give Year or Dates:	II WW		1 ☐ Yes 2 🙀 No	Specify	:		Sp	ecify: Whi	to.		
9	2 hour		15. Decedent's Educ	cation	1	6a. Dece	dent's Usual Occup	ation			16b. Kind	of Business/Inc	White		
215	hin 72 In "na Medi	ple	(Specify only highest grade	College (1-4or 5-	+)	(Give life.	kind of work done DO NOT use retire	during mos d)	st of workin	ng	Ben	dix Fie	1d		
2	giene giene	Completed	Listing in the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the sta	3+		Er	ngineer				Eng	ineerin	g		
D	be fited Hydrau doth	Be	17. Father's Name (First, Middle, Last)	C						(First, Middle,		тате)			
<u></u>	ould Men Parka	10	John W. Hamilton, Sr.  Mary Lillian Morris  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z												
Maryland 21215-0036	12 sh h and 7 is m traum			oe, Print) zife)			ng Address <i>(Street</i> 3 Rivulet				-				
	1 and Healt am 2		20a. Method of Disposition	rite)	20b. Place	e of Dispo	sition (Name of			minta,		and 210 ion - City or To			
nor	ages ant of it: If It		1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		-	matory or other pla ematory					sville,		and	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural, or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantrial must be notified at ancie.		21. Signature of Funeral Service License	99	11001					1					
ä	Dep lang		> MSK. Ha	dema	~	Y	Name and Addrew Vitzke Fu 5555 Twin	nera. Knol	Home 1s Ro	es, Inc	1umbi	a, Mary	land 2	21045	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused e cause on each lin	the death. [								Approximate Interval Bety	e ween	
	Physician		Immediate Cause (Final disease or condition	Atheros		1'C	Cardia	vaso	inlo	12 D	isea.	ie l	Onset and D	eath	
	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):									
	Lammer	پ	Sequentially list conditions,	Due to (or as a		20. of\:									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	Consequen	01).									
	execun n and ial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a	consequeñ	ce of):									
8760,	icate be executed physician and s the burial-transit	dical													
9	ng ph as th	Med	IF FEMALE:												
Вох	death certific attending pl	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 🗌 Fetal de	ath 3[	Ectopic pregnanc	У			23d	. Date of delive Month	,	'ear	
0	the a	by Physician/Me	1 Yes 2 No	4□ Pregnant at 9□ Unknown	time of death	n 5L	Other (specify) _						,		
P. 0.	that the de ed by the detached	/ Ph	Part II. Other significant conditions cor	tributing to death bu	ıt not resultin	ng in the u	nderlying cause giv	en in Part	I.	23e. Did t	obacco use	contribute to th	e cause of de	eath?	
ds,	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	d b)								10	Yes 2□N	lo 3 Prob	ably 4′ <b>⊈</b> ĵU	Inknown	
00	w requir s been si should	lete								24a. Was	an 2	4b. Were auto	osy findings a	available	
Be	The law ate has page 2 :	Completed					-				osy ormed? 2₽No	prior to cor death? 1 \(\sum \) Yes		tuse of	
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Plac	e of Death	(Check only					
<u>&gt;</u>	Physician: r this certific ral director,	To	1 ☐ Yes 25 €No	ospital: 1 ★ Inpatier		/Outpatier	nt 3 DOA Ott	ner: 4□N				Other (Specifi	•)		
n c	ding Physician: th. After this certifical funeral director,	lon;	27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28	b. Time of Injury	Wo	rk?		8d. Describe	how injury o	ccurred			
isi	death ctor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	Inv - At home	farm str		Yes 2		28f Location /	Street and N	umber or Rura	I Route Numi	her	
Division of Vital Record	l or Attendater death Diractor:	Certification;	4 Homicide determined	building, etc	. (Specify)	, raim, su	eet, radory, once			City or To	wn, State)	amber of riara	710010 740771	,01,	
	Hospita 24 hours Funeral stely filled		29a. Certifier 1 Certifying Phys	sician: To the best o	of my knowle	dge, deatl	h occurred at the ti	me, date a	nd place, a	and due to the	cause(s) an	d manner as st	ated.		
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	Medical	(Check only 2 Medicel Examily one)	ner: On the basis of and manner sta	examination	and/or in	vestigation, in my o	ppinion, dea	ath occurre	ed at the time,	date and pla	ace, and due to	the cause(s)	1	
	To the within 7 To the comple	Σ	29b. Signature and title of certifier				29c. Licens				. 1	igned (Month,			
,	11/		1 - / -				カレ	1372	-5		41	2310	0	-	
1	1		30. Name and address of person who co				Print)	10	1.00	N	in or	23/U d B	- 1600	10100	
	Sta	to	31. Date filed (Month, Day, Year)	7 HMUU[	ar's Signature	1-10	1900	RIL	104	1 4 5 (	(	4 15	NITIN	VIC	
	Registi		APP 2 8 2006	100		1									

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	Marylan	•	artment of H		d Mental Hyg	jiene	106	13358		
	95	9	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th	Vaas	3. Time of Death	_	
	Physici /Medic		John L. Herndor	1					April	1 ^{Day}	2006	2317 м		
	Examir		4a. Fecility Name (If not institution, give s Anne Arundel Med			_	4b. City, Town, or Annapo		Death		ounty of Death ine Aru	ınde1		
;; (3)	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H							s. 8. Date of Birth 9. Birthplace (State or F				
.55	Director		214-66-1833 XX	Feb 16	195	6 Mary	Tand							
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation				1	Od. Inside City Limits	_	
	Maryli f sho	ō!	Maryland Anne Ar	undel		othia						1 □ Yes 2 No		
	r 28a	rect	10e. Street and Number	<u></u>			10f. Zip Code			l 0g. Citize	on of What Coun	itry?		
	th witl	ai D	5226 Sands Rd.				2071	1		USA				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f show says injury or other traumatic event, the Medical Examinating the profitied at once.	by Funeral Director	11. Marital Status  MNever Married 2 Married 3 Widowed 4 Divorced	2. Was Deceder Armed Forces 1 Tes 2 Tes If Yes, Give Year or Dates	s? ¶No	? If Yes, specify Cuban, Mexican No 1 ☐ Yes 2€ No Specify:			? (Specify Yes or No- cuerto Rican, etc.)		Race - Americ Black, White, pecify: B15	etc.		
	2 hou	ted	15. Decedent's Educ	ation		16a. Dece	dent's Usual Occup	ation	(	16b. Kind of Business/Industry				
218	thin 7 e. e.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-40	r 5+)		kind of work done of DO NOT use retired	during most of f)	working			Maryland		
21	led wi	Con	9th	0		Lan	dscaper	50 14-45-4-	Name (Sing Adjuste		nway Ad	ım.	_	
and	ntal Period	Be	17. Father's Name (First, Middle, Last)  James Herndon						Name (First, Middle, 21 Abrims		umame)			
Ž	should nd Me mark imatic	ပ္	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Address (Street		or Rural Route Numbe		Town, State, Zip	Code) 21403	3	
Z	nd 2 alth ar 27 is 27 is ir trau		Cassandra Herndo	n(Daugh	nter)	1155	Freder	ick Do	ouglas St	. Ar	nnapoli			
Baltimore,	Pages 1 and the sunt: If Item ury or other		20a. Method of Disposition  1 Burial 2 Commation 3 Re 4 Donation 5 Other (Specify)	moval from Stat	. Ce	emetery, crei	of Disposition (Name of tery, crematory or other place)  CO Crematory 4-26-06  Date 20c. Location - City or Town, State Baltimore, Ma						1	
Balt	permit. Departr Imports sny inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Wm. Reese & Sons Mortuary, P.A.  82.1 West St. Annapolis, Md. 21401  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate											
				Approximate Interval Between										
46.	Physician		Immediate Cause (Final disease or condition	UPE	ver 6	gastra	Ditotia c	Ble	ed in			Onset and Death		
	/Medical Examiner		resulting in death)		is a consequ									
et.		er	Sa uentially list conditions If any, leading to immediate  Due to (or as a consequence ot):											
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
, O	icate be executed physicien and s the burial-transit	Exa	resulting in death) Last  Due to (or as a consequence of):										Ī	
8760,	ate be	dicai	d											
9	ertifica ding pl	Med	IF FEMALE:	sc. If yes, outcom	o of orogon									
Вох	death certific e ettending p id for use as	Physician/Med	in the past 12 months?		23	<li>d. Date of delive Month</li>	ery Day Year							
o.	the y th	hysic	1 U Yes 2 No 9 Unknown	4□Pregnant 9□Unknown		Jan. 0	Other (specify)							
٥,	requires that een signed b nould be dete	by Pi	Part II. Other significant conditions con	inbuting to death	but not resu	alting in the u	nderlying cause give	en in Part I.	23e. Did to	23e. Did tobacco use contribute to the cause of death?				
ıdş	w require been sig should b	ted t	(oronay arter	y D1300	ade				1 🗆 Y	es 2 🔀	No 3□Prob	ably 4 Unknown		
of Vital Records,	as b	Completed							24a. Was a			psy findings available		
= H	Th ate pag	Con							perför 1 ☐ Yes	med?	death? 1 ☐ Yes	2 No		
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Oth	or	Death (Check only or					
	Phys	- T	1 ☐ Yes 2 ☑ No	1 ☐ Inpa 28a. Date of Ir		ER/Outpatier 28b. Time of		4 🗀 (4015)	ng Home 5 ☐ Resid			′)	_	
Ou	Attending Phrades of death.  sctor: After the by the funeral	tion	1 Natural 5 Pending 2 Accident Investigation		Day Year)	Injury	Wor	k? Yes 2⊟No						
Division	spitel or Attendours after deatlers after deatlers seral Director: filled in by the	ertification:	3 Suicide 6 Could not be determined	28e. Place of I	njury - At ho etc. (Specify	ome, farm, str	reet, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Number,	_	
	Hospitel or A 4 hours after Funeral Dire tely filled in b	O												
	To the Hospitel within 24 hours a To the Funeral I completely filled	fedical	(Check only 2 Medical Examin	er: On the bes	of examinat	wledge, death tion and/or in	vestigation, in my o	pinion, death	place, and due to the occurred at the time, o	late and p	lace, and due to	the cause(s)		
	with To Con	Σ	29b. Signature and title of certifier	0.5	w	jas	29c. Licens	88543			signed (Month, $2$			
	1	r j	30. Name and address of person who con	npleted cause o	f death (Item	23a) (Type,	Print)	ha	NOST RIVE		h. a			
			Mayne D. Bles 31. Date filed (Month, Day, Year) APR 2 8 20	12 Rapid	strar's Signa	ture PC	ensulle	COL, I	NOST KIVE	× /	ערייו		_	
1	Sta Registi		á 5 5 0 0 0 0	00	are a signa	k	Cook 1							
DH	IMH 17 Rev 1/2	001	APR 2 8 20	mp		1	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1,perMDstate of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Samuel A. Henderson, Jr. 4 Month **Physician** Year 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NA nesus - word Center If Under 1 Year If Under 24 Hrs. 8, Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212.58.4990 1 M 2 □ F Director MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Madical Examinar must be radified at Ballimore MD Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1754 Homestead Street 21218 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other then "natural", or ite 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 4th grade 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Henderson, 8v. Samuel Weaver Addie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Addie B. Henderson/Mother permit. Pages 1 and 2 Department of Health a importent: if item 27 ie any injury or other tret once. 1754 Homestead Street Batto MD 21218 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State nnity (aneta) `4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Voughn C. Greene Funeral Services
4909 York Road Bartimore MD 21212 21. Signatur of Funeral Service Licensee lem 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Endstone Auto mune Deticen Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Cther (specify) 4 Pregnant at time of death P.O. 4 1 Yes 2 No 9 Unknown 9 Unknown ģ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Doknown Completed Mastolditis 24b. Were autopsy findings available prior to completion of cause of death? certificate has be inector, page 2 s 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 I rsing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 XND 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 2 29c. License number DUV59423 18 30. Na e and address of person completed cause of dec (Item 23a) (Type, Print) Ndidi Fembers 560 TOCK ROVER BLUD POR#303 Bultomore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖺 🖺 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April **Physician** JOYCE, JR. 22, 2006 FREDERICK CARL 3:40 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2□F June 27, 1925 Maryland 210-12-2483 80 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f shov The Medical Examiner must be putified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21704 8619 Pinecliff Drive USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 XYes 2 No
If Yes, Give
Year or Dates: 1943-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 Sales Executive Electronics other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H
27 is marked of
traumatic sver Pages 1 and 2 should I Rodalia Lavurn Martin Frederick Carl Joyce 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is sny injury or other trau 4107 Delancy Drive, Silver Spring, Maryland Kathleen Pearce, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Patrick's Cath. Cem. 4/26/2006 Mt. Savage, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford Fineral Home 21. Signature of Funeral Service Licensee 106 East Church Street, Frederick, Waryland 21701 M00999 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebral hemorrhage 10 hrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. East or Jarying Cause (Disease or injury that initiated events resulting in death) Last M.D. ? Due to (or as a consequence of) Tan rede ick To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown disease Coronary artery Congestive heart Fullure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Failure Chronic renal 1 ☐ Yes 2.2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No Pt fell down stairwry 10 04/21/06 Director: / 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 | Homicide 8619 Pirecliff Dr., Frederick, MD Home 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Gregory Guillo MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

604 Solarer Cut # 103

32. Registrar's Signature

29c. License number

D0047679

Frederick,

29d. Date signed (Month, Day, Year)

4, 22, 2006

latient Known as Deborah M. Voseph Box 68760 P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b-c,perFH.0855.5/2/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year Month 5:65 PM **Physician** April 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Peath 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 24 Hrs. of Baltimore 1+ospilal Sinai 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 360 - 44-9613 Usual Residence of Decedent 1 ☐ M 2 🗙 F Months Days Yrs. Neü Director 10d. Inside City Limits 10h Count 10c City Town or Location 10a State 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be rictified at Maryland 1 Yes 2 No Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Completed by Funeral 12. Was Degedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Blac 3 □ Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Day Care Teac 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be OSCOMD Innie 2 g hte, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relati ship (Type, Pri ) 2203 ohnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Carmel ' 4 Donation 5 ☐ Other (Specify) ------ 5/4/2006 22. Name and Address of Facility Joseph L. Russ Funeral Home, P. A. 2222 W. North Ave. Balto, Nd. 21216 21. Signatore of Funeral Service Acenses 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failute. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to /or as a concentration of the death.

Due to /or as a concentration of the death. Approximate Interval Between Onset and Death day **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Jivision of Vital Records, by edema 1 Yes 2 No 3 Probably 4 Munknown Completed breast 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2010 I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore MD Olander Sinai 32. agistrar's Signature 31. Date filed (Month, Day, Year) State APR 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene | | |

13362

					y	Cer	tificate of	Death	inoma, ny	Reg. No.	O i	000	) (
	Physici	an	1. Decedent's Name (First, Middle, Les						2. Date of De	ath Dav	Year	3. Time of I	
\$	/Medic		Zilla Newsom John					the Other Tarres are	April	24	2006	8:55	PM
Ž.	Examin	ner	4a. Fecility Neme (If not institution, given Blakehurst Commun:					4b. City, Town, or Towson	Location of Deatr	,	imore		
	Funeral		5. Social Security Number 6. S	ex 7. Aç	ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	r If Under 24 Hrs	8. Date of Birt			ace (State or	r Foreign
	Director	9	220-14-0109	□M 2XIF	90	Yrs.	Mioriano Bays	, Hours	8. Date of Birl (Month, Da Februar	ÿ 28,191	.6 V	ace (State or y) 1rgin:	ia
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	cation				10	d. Inside City	y Limits
	e Man	ctor	Maryland Baltimon	re	ŗ	Towson						1 ☐ Yes	2 <b>X</b> ) No
	vith th	Funeral Director	10e. Street end Number				10f. Zip Code	,		10g. Citizen of		•	
	eath v	eral	1055 W. Joppa Rd.	12. Was Decedent	Ever in U.S	S 13 W	2120		Specify Yes or No	United	State e - America		
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hydene. Department of Health and Mental Hydene. Important: If item 27 is marked other then "neturel" or items 23s or 28e-f show eny injury or other treumatic event, the Modical Expriner most be notified at once.	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			Yes, specify Cult  ☐ Yes 2XX No	Hispanic Origin? (S ban, Mexican, Puer o Specify:	to Rican, etc.)	Bla	ck, White, e	tc.	
2-0	netui	eted	15. Decedent's Ed (Specify only highest gre			16a. Deced	ent's Usuel Occu	pation during most of wo	rking	16b. Kind of B	usiness/Indu	ustry	
121	within ene. then	mp	Elementary/Secondary (0-12)	College (1-4or	5+)		nemaker	90)		own :	home		
b D	e filed Il Hygi other	Be Completed	17. Father's Name (First, Middle, Last)		-	1101	nemarer	18. Mother's Na	me (First, Middle,				
ylar	Menta Menta arked atic ev	To E	John Franklin News	som				Ostella	Mary Pe	rry			
Mar	12 sho	e s	19a. Informant's Name/Relationship (7) Ostella J. Cowan/o	•			-	oring Ave		er, City or Town, erville		²⁰⁰ 0000000000000000000000000000000000	Ł
ē,	Healt Healt tem 2	1	20a. Method of Disposition	adgitter	20b. Pl		sition (Name of patory or other pla		Date	20c. Location			
E O	Page: nent of nt: If i		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		_		cremato		4/27/06	Baltim	ore, M	Maryla	ınd
Baltimore,	permit. Departn Importa eny inju		21. Signature of Funeral Service Licen	see		22.	Name and Addr	ess of Facility ell-Wiede York Rd.					
	20 E 9 8		John O. Mutc	hell		Ì	6500 	York Rd. more. MD	21212				
			23a Part1. Enter the disease, or compensors, or heart failure. List only	olicetions that caused one cause on each li	the death ne.	. Do not ente	r the mode of dy	ing, such ás cerdia	c or respiratory ar	rest,	1	Approximate nterval Betw Onset and De	veen
1	Physician /Medical		Immediate Cause (Final disease or condition	a. Ische	mic	Cal	diany	opathy				Years	
	Examiner	_	resulting in death)	a		as a consequ		41.				7 60 11 ]	
	rted Insit	Examiner	•	b			, ,				-		
o,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use es the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertining Cause (Disease or injury that initiated events		Due to (or	as a consequ	ience or):				1		
68760,	ate be hysicii the bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or	as a consequ	ence of):						
9 X	certific ding p	2		d				,					
80	d for u	Ician	Part II. Other significent conditions co	entributing to death b	ut not recui	ting in the un	derlying cause d	iven in Part I	23h Did t	obecco use co	ntribute to 1	he cause of	f death?
0.	that the death ce ned by the attendii detached for use	Physician/	Tarrii. Olilor signinosii conditions ce	THI DUTING TO GENTLY D	at not resu	iling in the an	derrying cades gi	you life alt i.	1 <b>½</b>			ibly 4 □ U	
S,	w requires that been signed I should be det	þ							/		045 144-		
Vital Records,	requi	Completed							24a. Was a	an autopsy rmed?	avail	e autopsy fin lable prior to pletion of ca	)
Ř	The law ate has page 2	фшо							1 🗆 Y	es 2DNo		eath? Yes 2□ N	No
Ig	ysician: The I	Bec	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only o				
5	hysic this ce al dire	၉	1 ☐ Yes 2 Ď¢No	Hospital: 1 Inpatie	1	R/Outpatient	3LI DUA		lome 5 Resid				
50	Attending Physician: r death. ector: After this certific by the funeral director.	Certification:	27. Manner of Death 1	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Inju Wo	ıryet ork? ]Yes 2 ∐No	28d. Describe h	iow injury occuri	red		
DIVISION	Atten er dear ector: by the	tifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At hor	me, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Numb	er or Rural	Route Numb	per,
בֿ	To the Hospital or Attending Phywithin 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral												
	B Hosi	edical		rsicien: To the best iner: On the basis of end manner st	examination								
	within To the	Me	29b. Signature and title of certifier				29c. Licen			29d. Date signe			
,	0		Muartin	N				58303		April 2	6 200	E	
1		- 1			AL - (14								
10	) '		30. Name and address of person who of AMUN CHARLES.  31. Date filed (Month, Day) years) 8	rw (a.G.)	eeth (Item)	23a) (Type, P 26444	Frint) BA	17 muze	m 212	94.			

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Man &

			1 - For Amend Ite	State of Marylan	d/Dep <b>per Fil</b> <i>Ce</i>	artment of H G854 04 hillicate of I	lealth and 128/060 Death	Mental Hy	giene	C Proces	13364
**	Physic	an	1. Decedent's Name (First, Middle, Las	()				2. Date of De	eath Day	Year	3. Time of Death
	/Medi		EUNICE				KARTMAI			006	11:57A M
	Examir		4a. Facility Name (If not institution, give	· ·		4b. City, Town, or		ath	4c. Count	y of Death	
W.			JEWISH CONVALESCE			BALTIMO				LTIMO	
<b>1</b>	Funeral Director		5. Social Security Number 6. Se 359-10-4534 Usual Residence of Decedent	7. Age (In yrs. 86	Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M		,1919	9. Birthp Cour	place (State or Foreign ntry) I L
	72 hours after death with the Maryland nature!', or iteme 23a or 28a-1 show ilsel Examinat must be notitled at		10a. State 10b. County	10c. Cit	y, Town or Lo	ocalion				1	10d. Inside City Limits
	Man	to	MD BALTI	MORE	BALT	IMORE					1 ☐ Yes 2 🙀 No
	th the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a c	Funeral Director	3302 NORTHBROOK F	ROAD			21208	3		US	A
	r dea	Inei	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? n. Mexican, Pu	(Specify Yes or No	0- 14. Ra	ce - Americ	can Indian,
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 💢 No If Yes, Give		1 ☐ Yes 2 🕅 No	Specify:	, =,	Specia		WHITE
9	hour ture!		3   Widowed 4 □ Divorced  15. Decedent's Edi	Year or Dates:	160 Dans	danda Harri Ora					
5	in 72 in 72	ojet	(Specify only highest grad	de completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of v ()	vorking	16b. Kind of E	usiness/in	dustry
212	with iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	MAKER	,		OWN	HOME	
b	filed I Hyg other	0	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle			
lar	ould be Menta arked atic ev	To B	SAMUEL		GORD	ON	BERTH	ŀΑ	UNKNOW	IN	
Maryland 21215-0036	nd 2 shou alth and N 27 is ma		19a Jeformani's Name/Relationship // Shelley Sarstiel	DAUGHTER		ng Address (Street a					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if itam 27 is marked other then "naturel", or iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State Bala	Pace of Dispo	psition (Name of managed States place BANSHE V	ESHEAR	Date 4/26/06 -	20c. Location Reister	- City or To	own, Slate MD
Balti	permit. Page Department Important; if any injury of		21. Signature of Funeral Service Licens		2:	2. Name and Addres	ss of Facility	SOL LEVIN	SON & B	ROS.,	INC.
	6 5		23a. Part1. Enter the disease, or comp	lications that caused the deat						,	Approximate
I	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	me cause on each line.	1607						Interval Between Onset and Death
	Examiner			Due to (or as a conseq	uence of):						
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence.	uence of):						
,8760,	cate be executed obysicien and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequent	uence of):						
9	iffical g ph	ledi									
.O. Box	The law requires that the death certificate be executed tite has been signed by the attending physicien and oate 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. II yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)				ite of delive	ery Day Year
Ω_	that i	Y Ph	Part II. Other significant conditions co	ntributing to death but not res	ulling in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use con	Inbute to th	ne cause of death?
rds	n sign	d by						1 🗆	Yes 2□No	3 Prob	pably 4 Nunknown
00	w requir s been si should l	Completed						24a. Was	an 24h	Were auto	psy findings available
Re	: The law cate has l	E						autor perfo	psy ormed?	prior to co death?	mpletion of cause of
tal		BeC	25. Was case referred to medical				36 Place of F	1 Tes		1 🗆 Yes	2 No
<u>&gt;</u>	Physician: this certific ral director,	To B	examiner?	Hospital: 1 Inpatient 2 I	ER/Outpatier	nt 3 DOA Othe	200	Home 5 Resi		or (Specif	···
0	ding Physician: h. After this certific funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				how injury occur		7/
Ö	Attending r death. ector: After by the funer	atio	1  ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □ No				
Division of Vital Records,	al or Atte s after de il Directo id in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st	reet, factory, office		28f. Location ( City or To	Street and Numi wn, State)	ber or Rura	i Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsicien: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	ne, date and pla pinion, death oc	ice, and due to the curred at the time,	cause(s) and m date and place,	anner as si and due to	tated. the cause(s)
	P > P 3	M	29b. Signature and title of certifier			29c. License			29d. Date signe		
			1(12 K	S.RAO. M.C	)	04	3463	- 1	APRIL'	24 7	2006
	12		30. Name and address of person who c		23a) (Type,	Print) K.S.	RASIF	10019	n 0 2	-117	~
5.3	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signa		entis					

			1 - For State Registrar	State	of Maryland		artment o			d Mental		ene I. No.	0.6	1336	55
	Physici	an.	1. Decedent's Name (First, Middle	le, Last)						2. Date of		Day	Year	3. Time of	
	/Medic		Signor Lucas							Apri	1	25	2006	5:20	P ^M
E	Examin	er	4a. Facility Name (If not institution		ımber)		4b. City, To			eath		4c. Co	unty of Death		
		with the	1012 Wedgewood  5. Sociat Security Number	Road 6. Sex	7. Age (In yrs. la	ast hirthday)	Ba If Under 1	1timo	Ore Under 24	Hrs. 8 Date (	of Birth		Q Right	olace (State o	r Comian
of the second	Funeral Director		239-60-4443	1 M 2 □ F	67	Yrs.				Min. 8. Date of (Montile O4/2	), Day, )	(ear)	Cou	ntry) Carol	
			Usual Residence of Decedent		07					04/2	.2/1.	737	MOLCI	LCaro	Tha .
	nylan show	_	10a. State 10b. County		10c. City	, Town or La	cation							10d. Inside Ci	
	8a-f	Director	Maryland		B	Baltimo								1 X Yes	2   NO
	with ti	吉	10e. Street and Number	D .			10f. Zip Co						of What Cou	ntry?	
	eath ve 23,	erai	1012 Wedgewood		edent Ever in U.S	S 13 1		229	nic Origin	2 (Specify Ves.)		U.S.	A. Race - Ameri	can Indian	
10	ter d	Funerai	1 Never Married 2 Mar	Armed F					lexican, P	? (Specify Yes ouerto Rican, etc.	)	14.	Black, White,		
036	al', o	þ	3 ☐ Widowed 4 🏋 Divorced	If Yes, G	ive		1□Yes 2🏋	No Sp	oecity:			Sp	ecify: Bla	ıck	
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show disal Examinat must be notified at	Completed		nt's Education est grade completed			dent's Usual C			working	16	b. Kind	of Business/In	dustry	
2	within ene. then "	npie.	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT use i	retired)		g		Cons	structi	on	
121	filed withi Hygiene. other then		12 17. Father's Name (First, Middle,	( act)		Fork	Lift 0			Name (First, Mi	iddio A4s				
anc	ntal H	Be	Odis Lucas	Lasij						e Wiggi		liden Su	mame)		
Maryland	2 should be tand Mental is marked o	ဍ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	na Address (S			r Rural Route N		City or To	own. State. Zir	Code)	
	tra		Mina Tiller / 1	, , , , , ,										,	
Baltimore,	of Health Item 27 other tr		20a. Method of Disposition			lace of Dispo	sition (Name natory or othe	of	some,	Baltim Date	20	c. Locat	ion - City or To ng Hop	own, State	
Ë	0 0 = =		1 □turial 2 □ Cremation 4 □ Donation 5 □ Other (S		State		-		v 105	/02/2006			Carol:		
alti	inju	1	21. Signature of Funeral Service	Lidensee						The Der					.A.
<u>m</u>	Dep Impe		10 - W	C.						ve., Ba					
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that t only one cause on	caused the death each line.	. Do not ent	er the mode o	of dying, su	ich as car	diac or respirate	ory arres	t,		Approximate Interval Bety	ween
	Physician	1	Immediate Cause (Final disease or condition	a D(	a beter	o Co	mpl	110	170	MS			7	Onset and C	WS
0	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):									
*		_	Sequentially list conditions,	b. — Due to	(or as a consequ	ionoo of									
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	(or as a consequ	361106 01).									
	be executed sicien and burial-transit	xar	that initiated events resulting in death) Last	c	(or as a consequ	ience of):									
8760,	ate be executed hysicien and the burial-transit			d											
9	tificate ng phys as the	Physician/Medical		T											
Вох	The law requires that the death certific ate has been signed by the ettending p age 2 should be detached for use as:	an/\	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnar birth 2 Petat		Ectopic pregi	nancv				23d	. Date of delive		
	the et hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of de		Other (speci						Month	Day 1	/ear
P.0	that the de ed by the detached		Part II. Other significant conditi	One contribution to a	death but not resu	ulting in the A	ndorbina ogur	ce awas in	Part I	230	Did toba	cco uso	contribute to t	ha cause of d	eath?
Ś	ires tha signed I d be det	i by	Lictor	SF Car	1100	A	VH	011	mi		1 🗌 Yes	1	to 3 ☐ Prot		Jnknown
of Vital Records,	w requir been si should I	Completed	- Holy	1 00	TOUCH C			7	///	٦	-				
Rec	The law ate has page 2	m								-	Was an autopsy perforige		4b. Were auto prior to co death?	mpletion of c	ause of
a		e Co	25. Was case referred to medica						Diagram of	1 TY		Ne	1 🗆 Yes	2 No	
<u>=</u>	Physician: this certific ral director,	To B	examiner?	Hospitat:	Inpatient 2 🗆 E	ER/Outpatien	t 3 DOA	Othor	Nursin	Death (Check of		ca 6	Other (Specif	541	
0	g Phy ter this seral c		27. Manner of Death	28a. Date		28b. Time of		Injury at Work?	1401311	28d. Desc				<i>y</i> /	
Division	Attending r death.  ctor: After by the fune	Certification:	1 Natural 5 Pendir 2 Accident investi	19	illi, Day 16al)	Injury	М	1 🗆 Yes	2 🗆 No						
i	after deatl Director:	tific	3 Suicide 6 Could 4 Homicide determ	nined 286. Plac	e of Injury - At ho		eet, factory, o	ffice		28f. Locati City o	on (Stre	et and N State)	umber or Rura	I Route Num	ber,
	irs aft rel Di					·									
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai		ng Physician: To th Examiner: On the t	pasis of examinat										)
	ithin 2 the mplei	Med	29b. Signature and title of certifie		ner stated.		29c. L	icense nur	mber		290	. Date si	igned (Month,	Day Year)	
	F 3 F 8		1/1/10	FIM	IMA L	10	T	12	70:	3/-		10	17-1	106	
h	A		30. Name and address of person	who completed cau	ise of death /Item	23a) (Tune	Print)	) /	10,	10	(	7	14/	IUN	-
X			TAV	Le EI	/ANS	\$ 1	MV	).				,			
	⊳ ⊭ Sta	ite	31. Date filed (Month, Day, Year,		Registrar's Signat	ture				·				· · · · · · · · · · · · · · · · · · ·	
	Registr	ar	APR 2'8	2006	was d	N. Alex	and .								

			For State Registrar	State of M	1arylan		artment rtificate			and M	F	Reg. No.	106	13366
1,000	Physici	20	1. Decedent's Name (First, Middle,	Last)							<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
.33	/Medic		Michael M. Lee								04	25	2006	2:10p M
	Examin	er	4a. Facility Name (If not institution, g	rive street and number	r)		,		Location o	of Death			County of Dea	
T. S		<i>y</i>	Casey House  5. Social Security Number 6	Sau 7 A	an /In ure	last birthday)	If Under	ckvi	If Under	24 Hrs.	8. Date of Birtl	h	ontgom	
Se .	Funeral Director		212-42-6274	Sex 7. A	62	Yrs.	Months		Hours	Min.	(Month, Day	v, Year)		thplace (State or Foreign puntry) ew York, NY
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	f sho	ō	MD Mont	gomery	G	ermant	own							1 XYes 2 □ No
	28a	Je C	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	ountry?
	3a ol	0	19853 Century B	1vd #201				2	0874			US	A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "neturel", or Items 23s or 28s-f show any injury or other traumatic event. I've Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marned  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces d 1 ☐ Yes 2 If Yes, Give Year or Dates	s? ] No	į.	Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)		4. Race · Ame Black, Whit Specify: B1	te, etc.
21215-0036	ture sture	ed	15. Decedent's	Education		16a. Dece	dent's Usua	I Occupa	ation			16b. Kin	d of Business	/Industry
15	n "n	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	r 5+)	(Give	kind of wor DO NOT us	k done d e retired	during mos )	t of worki	ng			
212	yiene giene r tha	Completed	Elementary/Secondary (0-12)	5+		Ma	nager					R	etail	
ਰੂ	other	Be C	17. Father's Name (First, Middle, La	ist)							(First, Middle,			
<u>lar</u>	uld by Menta Menta rrked	To E	Alvin J. Lee								ulia De			
Maryland	nd 2 sho lith and I 27 is ma r traume		19a. Informant's Name/Relationship Shirin Lee/wife	(Type, Print)							l Route Numbe 1 Germa			
Baltimore,	ages 1 a ant of Hea t: If Item y or othe		20a. Method of Disposition  1 ☐ Burial ②☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			Place of Disponentery, cres					7-2006		ation - City or eltsvi	Town, State 11e, MD
Baltir	permit. P Departme Importen Iny injur		21. Signature of Funeral Septica Li	(m)	MOO	-	2. Name an Rapp	d Addres Fun	s of Facili	& Cr	emation	ı Ser	vice	
	UDZ W U		23a. Part1. Enter the disease, or c	CHAMICIAN COM		h. Do not en	933	Gist	Av S	Silve	r Sprin	ig MD	20910	Approximate
			shock, or heart failure. List or	nly one cause on each	line.	ii. Do not di	tor the mod	o or cym	g, odom do	04.0.40				Interval Between Onset and Death
F-16	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Pancre		Cance	r							
	Examiner			Due to (or a	as a conseq	uence of):								
88 W		-	Sequentially list conditions, if any leading to in-mediate	b. Due to (or a	as a cons	uence of :								
	nsit	Ę.	Cause (Disease or injury											
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	as a conseq	uence of):								
760,	ate be executed hysician and the burial-transit	cal		d										
89	ificate g phy as the													
.O. Box	ie death certificat the attending phy hed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of d	death 3	⊒Ectopic pr ⊒ Other (sp					2	3d. Date of de Month	olivery Day Year
<u>α</u>	that the de ned by the a detached		Part II. Other significant condition	s contributing to death	n but not res	ulting in the u	anderlying c	ause givi	en in Part I	ı.	23e. Did to	obacco us	se contribute t	o the cause of death?
Records,	se und	d by									1 🗆 🗅	Yes 21	]No 3□P	robably 4 Unknown
Sor	w requir	Completed									24a. Was	an	24b. Were a	utopsy findings available
Re	The law ate has b page 2 si	E G										rmed?	prior to death?	completion of cause of
a		C	25. Was case referred to medical	P					26 Plan	o of Doot	1 ☐ Yes h (Check only o		1 □ Ye	s 2 No
Vital		o B	examiner?	Hospital:	atient 2	ER/Outpatie	nt 3 DC	Oth					- €Other (Spe	ecify) Hospice
of	ting After fune	<b> -</b>	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,		28b. Time of Injury		8c. Injun Wor			28d. Describe			nospice
Division	or Attending after death. Director: Afte d in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Place U	Injury - At h etc. (Specia	ome, farm, st fy)	reet, factory	, office			28f. Location (S City or Tov		l Number or F	Rural Route Number,
_	urs urs arel	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basis	s of examina	owledge, dea ation and/or in	th occurred	at the tin	ne, date ai pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner a place, and du	us stated. te to the cause(s)
	To the Hosp within 24 ho To the Fund completely f	Med	29b. Signature and title of certifier	and manner	Stateu.		290	c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)
	N		, CK.	1 - 2	~	17			35635				-26-20	
	, 0		30. Name and address of person	o completed cause of	of death (Ite	m 23a) (Type	, Print)		_	-			-	
1	)		Joseph Kaplan M	ID 6001 Mur	caste	r Mill		Rock	ville	e MD	20855			
19 60	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 8	32. reg	istrar's Sign	ature	certi	•						

Months

Center

7. Age (In yrs. last birthday)

82

Certificate of Death

Days

Hours

State Registrar

cai

1 - For State Registrar

5. Social Security Number

169-14-2249

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Decedent's Name (First, Middle, Last)

Robert D. Leighton, Sr.

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical

1XM 2□F

DHMH 17 Rev 1/2001

2. Date of Death 3. Time of Death 2006 MenteIL 3:14 PM

4c. County of Death 4b. City, Town, or Location of Death

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

23d. Date of delivery

Day

Month

Year

If Under 1 Year | If Under 24 Hrs. 10/18/1923 New York

10d. Inside City Limits 1 ☐ Yes 2% No

10g. Citizen of What Country? U.S.A.

14. Race - American Indian. Black, White, etc Specify: White

16b. Kind of Business/Industry

Steel Manufacturing Ind.

18. Mother's Name (First, Middle, Maiden Sumame)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

528 Rock Run Road - Port Deposit, Maryland 20c. Location - City or Town, State

Highview Memorial Gdns.04/29/2006 Fallston, Maryland

22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A.

11750 Belair Road - Kingsville, Maryland 21087

Approximate Interval Between Onset and Death

1 Yes 2X No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 24 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier M D31826 26-06 MARICIA hard

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE TOWSON MARYLAND 21204 RICHARD LINTHICUM, M. D.

31. Date filed (Month, Day, Year) 32. Registrar's Signature falls

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#31, see 37 per DWR 0854 4/28/06 TT Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year 26 Barbara Lavery O 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beaverbrook Corner Columbia Howard 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F BbYrs. 214-10-6699 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits If item 27 Is marked other than "natural", or items 236 or 286-f show or other traumatic evant, the Medical Exert and must be notified at Columbia 1 Yes 2 No Director WD Howard WD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Beaverbrook 4994 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify. þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item ZT is marked oth any injury or other traumatic event, QDC8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ira F. Willing Rachel Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 Brumfield Circle Eldersburg, MD 21784 Debbie Joynes - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory 4/28/2006 Catonsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Euneral Service Licenses 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of]: Examiner the burial-transit Due to (or as a consequence of): attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform CHEX certificate 1 Yes 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tyes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the Diractor; 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours after To the Funarel Dira 29a Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical | Certifying Frigation: 10 the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

ARVIND

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

DESL

EA

YLEN BURN

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

115

32. Registrar's Signature

DESAI

		ŀ	1 - For Stete Registrer	State	of Marylan	nd / Depa <i>Cei</i>	artment of H rtificate of	lealth and <i>Death</i>	Mental Hygi	ene 0 0	6	13369
	Dhyaiai		1. Decedent's Name (First, Middle	e, Last)					2. Date of Death Month		Year	3. Time of Death
	Physici /Medio		Helen Lloyd						April 2			2:00 P.M
1	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o	r Location of Dea	th	4c. County o	f Death	
			Summit Park N					sville			timo	
ľ	Funeral Director		5. Social Security Number 217–16–0727	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	1ast birthday)  Yrs.	If Under 1 Year Months Days	Hours Min				lace (State or Foreign try) 1and
	and		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	ty, Town or Lo	cation				10	0d. Inside City Limits
	f eho	៦	Maryland Balti	mara		tonsvi					1	1 ☐ Yes 2½ No
	28a-	Director	10e. Street and Number	more	U.S.	LONSVI	10f. Zip Code		10	g. Citizen of Wh	at Count	tn/2
	with	١	17 Stout Run Co	urt			2122	0		USA		
	has 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. 1			Specify Yes or No-	14. Race		an Indian.
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28a-f ehow eumatic event, the Medical Examble must be incitited at	by Fun	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	Amed F ied 1 ☐ Yes If Yes, G Year or I	2∰ No ive	1	f Yes, specify Cub 1 ☐ Yes 2 🌠 No	an, Mexican, Puè	Specify Yes or No- rto Rican, etc.)		White, e	
ğ	2 hou	ed	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Bus	iness/Ind	lustry
715	Ned	Completed	(Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	orking			
212	d with	mo;	11	College	19401 37)	Home	maker			Own H	ome	
g	m - 0 5	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle, M	laiden Sumame,	)	
Na	ould be i Mental I arked o	To [	Jerome Sauerv	ald				Pearl	Morrison			
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic es ance.		19a. Informant's Name/Relations		1.				ural Route Number,			
<u>2</u>	and sealth m 27 her to		Andrea Lanahan	Daug	ghter			Court;	Catonsvil			
Baltimore,	Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 △Burial 2 □ Cremation	3 □Removal from		emetery, crer	sition (Name of natory or other plac	ce)	Date 2	0c. Location - C	ity or Tov	wn, State
Ē	tmen tent: jury		' 4 ☐ Donation 5 ☐ Other (S		Lou	don Pa	rk Cemete	ery   4/2	8/06 Ba	altimore	, Ma	aryland
ä	Depar Mpor mpor my in		21. Signature of Fun ral Service	Lic Isee	11/	22 F	. Name and Addre Tuneral H	ss of Facility St ome of C	erling As	nton Sc e. Inc.	hwah	witzke
	40200		OCO Poets Estaviba disease as	A line in a single	anuand the deat	<u> </u>	.630 Edmo	ndson Av	atonsvill enue; Cat	ońsvill		
١.			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.				ic or respiratory arre	st,		Approximate Interval Between Onset and Death
8	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			throm be	2515				
	Examiner	1		Due to	(or as a conseq	uence of):						
		<u>~</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseq	uence of):					-	
	nted Insit	min	Cause (Disease of Injury		,							
,	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	c	(or as a conseq	uence of):						
8760	cate be executed physician and the burial-transit	dical		d								
9	tificat ng phy as th	ledi		1		v a.e						
Box	death certifii e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnancy	,		23d. Date		
	0 0	sicia	in the past 12 months?  1  Yes 2 No		nant at time of d		Other (specify)			Month	n [	Day Year
о. О	at the de I by the a stached t	Phy	9 Unknown									
Vital Records,	The law requires that the site has been signed by the sage 2 should be detached.	by	Part II. Other significant condition	ns contributing to c	leath but not res	ulting in the u	nderlying cause giv	en in Part I.				e cause of death?
000	s been si	Completed							24a. Was an		ere autop	sy findings available
ř	: The law cate has   , page 2 s	mo							autopsy perform 1 Yes 2	ed? de:	or to com ath? ] Yes 2	rpletion of cause of
<u>ta</u>		0	25. Was case referred to medical					26. Place of De	ath (Check only one			5 140
	ysicien: iis certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA Oth		Home 5 ☐ Resider		(Specify)	)
Division of	nding Phy th. : After thi funeral		27. Manner of Death 1	9	of Injury oth, Day Year)	28b. Time of Injury	28c, Injur Wor	y at	28d. Describe how			
)IVIS	after death after death Director:	Certification;	3 Suicide 6 Could r 4 Homicide determ	ned 288. Place	e of Injury - At ho ling, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number State)	or Rural	Route Number,
	To the Hospitel or Attending Physicien: Whith 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		(Check only 2 Medicel	Exeminer: On the b	asis of examina	wledge, death	n occurred at the tir	ne, date and place	e, and due to the cau urred at the time, dat	use(s) and mann	ner as sta	ated.
	the I hin 2 the I	Medical	one) 29b. Signature and title of certifier	and mar	ner stated.		29c, Licens					
	T wit		> ) Laven	^ -	M. N			9 5 8 6 7 6		d. Date signed (		
. 7								7 3 4 6 76		April i	- 11	
1	,		30. Name and address of person Karen Babit	+ , M.D.	75 M	ain St	reet, su	11te 20.	o Reiste	13 pwn	M	1) 21136
	Sta Registr	**	31. Date filed (Month, Day (gar)	32 2006	egistrar's Signa	iture	sole)					

		Pleas	se Type or Print					•	_	ible.	
		1 _ For State	State of Mar	-				ental Hyg	liene	0.6 - 1	3370
	_	Registrar	( 1)		erunca	ite of Deat		2. Date of Dea	eg. No.		T:- (D - 1
Physic /Med		1. Decedent's Name (First, Middle Victoria		eanor_		Lewis		Month HOTI	Day	2006	5.15 p M
Exami		4a. Facility Name (If not institution,	give street and number)		4b. Cit	y, Town, or Location	13 1	* 1	4c. County	y of Death	•
	1		neral HOSPIH	1011	16	atmove ler 1 Year If Und		ry		0.00	
Funeral Director	~	5. Social Security Number 217–20–6276	1 N 947-E	in yrs. last birtho	Month		rs Min.	8 Date of Birth (Month, Day	, Year)	9. Birthplace Country)	e (State or Foreign
p k		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town o	r Location					10d	Inside City Limits
Aaryla Febo	ō	MD Balti		Caton		۾ [					1 Tes 2 No
the N	by Funeral Director	10e. Street and Number	IIIOL G	- Cu Con		Zip Code			Og. Citizen of	What Country?	?
3 with	ā	7 D Rambling	Oaks Way			2122	8			S.A.	
death ms 2	Jera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec	pedent of Hispanic pecify Cuban, Mexi		offy Yes or No-		ce - American	
after or Its	Fu	1 ☐ Never Married 2 ☐ Marri				No Spec		iloan, etc.)	Specif	ck, White, etc.	
illed within 72 hours after death with the Maryland Hygiene. Hygiene. thar then "natural", or Items 23a or 28a-1 show ent, tre Madical Examinar must be notified at		3 ₩ Widowed 4 □ Divorced	Year or Dates:								
nati	Completed	15. Decedent (Specify only highes	s Education t grade completed)	(6	ecedent's Us Five kind of v fe. DO NOT	sual Occupation work done during m	nost of workin	g	16b. Kind of B	Business/Indust	try
withir she.	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Nurs	•			Pri	vate I	Outy
Hygid Hygid		17. Father's Name (First, Middle, I	1				other's Name	(First, Middle,			4
id be ental	To Be	Albert Prito	hett Sr.			Re	na Mo	rris			
Lai y allo L L L 2 should be filed within and Mental Hygiene Is marked other then sumatic event, ITAM	-	19a. Informant's Name/Relationsh		19b. M	lailing Addre	ss (Street and Nur	m <i>ber</i> or Rural	Route Number	, City or Town	, State, Zip Co.	de)
5 5 5 N 5		Lester H. Wal	lace SrSc	on 7 I	Ram	bling O	aks W	ay, Ca	tonsv	ille,	Md 2122
Daltimore, permit. Pages 1 an Department of Heali Important: If Item 2 ery Injury or other once.		20a. Method of Disposition		20b. Place of D	isposition (A	lame of r other place)	Da	ate	20c. Location	- City or Town,	, State
Definition  Definition Pages Department of mportant: If it is not injury or one.		1√ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _i	ecify)	Mt. C	alva	rv	4/27	/06 G	len B	urnie	Md
Dall permit. Departn Imports eny Inju	1	21. Signature of Faneral Service I	icensee		22. Name	and A dress of Fa		,			
0 83558		Myrett	Z K. Y			Wabash .		Baltim	ore,	Md 21	L2 <b>1</b> 5
		23a. Fart1. Enter the disease, or shock, or heart failure. List	complications that caysed the only one cause on each line.	e death. Do not	enter the m	ode of dying, such	as cardiac or	respiratory arr	est,	Int	proximate erval Between
Physician		Immediate Cause (Final disease or condition	Sons	15						Or	nset and Death
/Medical Examiner		resulting in death)	Due to (or as a c	,							
Examiner		Sequentially list conditions,	b. acute	Mese	nte	ric I	-Sch	emic			
ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	consequence of):	•						
be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):	:						
te be executed ysicien and ne burial-transit	Cal										
The colds, r.C. box 001  The law requires that the death certificate at has been signed by the attending physoage 2 should be detached for use as the			d								
certii nding use a	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy					23d. Da	ate of delivery	
d for	cia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tin		3 ☐Ectopic 5 ☐ Other (					onth Da	y Year
oy the	hys	9 Unknown	9□ Unknown								
w requires that is been signed to should be det	by P	Part II. Other significant condition	ns contributing to death but	not resulting in th	ne underlying	g cause given in Pa	art I.	23e. Did to	bacco use con	tribute to the c	ause of death?
requires neen sign								1 🗆 Y	es 2 🗆 No	3 Probably	y 4 Denknown
aw re	ompieted							24a. Was a		Were autopsy	findings available
The !	E			-				autops perfori 1 Yes	med? _	death?	etion of cause of
lan: rtiffica	Be C	25. Was case referred to medical				26. Pl	ace of Death	(Check only on			
ysic ysic nis ce	10	examiner? 1 Tes 2 No	Hospital: 1 Impatient	2 ER/Outpa	atient 3 🗆 I	DOA Other: 4	Nursing Hom	ne 5 🗆 Reside	ence 6 □Oth	ner (Specify)	
ding Ph ding Ph th. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Tim		28c. Injury at Work?	2	8d. Describe h	ow injury occur	rred	
endii Bath. or: A	catio	2 ☐ Accident investig	pation		М	1 ☐ Yes 2	No				
or Atternation by the by the	Certification:	3 Suicide 6 Could r 4 Homicide determi		r - At home, farm (Specify)	, street, fact	ory, office	2	8f. Location (Si City or Town		ber or Rural Ro	oute Number,
urs af											
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has	edical	29a. Certifier 12 Certifyin (Check only 2 Medical I	g Physician: To the best of examiner: On the basis of examiner and manner state	xamination and/o	or investigati	ed at the time, date on, in my opinion, o	and plane, a death occurre	d at the time, d	ause(s) and n ate and place,	and due to the	d. e cause(s)
thin 2 the mplei	Med	29b. Signature and title of certifier	and manner state	u.	2	29c. License numbe	er		9d. Date signs	ed (Month, Day	v. Year)
8 48 4		1	2n y	12		2951	42		4.	21-0	(0
1 Y		30. Name and address of person	who completed earner of de-	- IhiD.	ne Print	019	10		-		
1		Ali Mirah	rahimi mid	Clan	nar.	land G	re nord	il th	Softal		
S	ate	31. Date filed (Month, Day, Year)	32 Registrar's	-	IN	m C	W L	~ [ U	JUIN		
Regis		ADD 9 0	2006	M Z	Books	9					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland		artment of H tificate of L			giene Reg. No.	06	13371
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	uth Day	Year	3. Time of Death
	Physici /Medic		MERRILL TRE	SHMANN LEE				April		2006	8:05A M
)	Examin	er	4a. Facility Name (If not institution, give st Union Memorial Hosp	oital		4b. City, Town, or Baltim	ore			N/A	
	Funeral Director		5. Social Security Number 6. Sex 220-09-3106	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9,1920	9. Birthpl Coun Mary I	ace (State or Foreign try) and
	show		10a. State 10b. County	10c. City	Town or Lo	cation				10	Od. Inside City Limits
	Mary	tor	Maryland N/A	Bal	timor	е					XX Yes 2 □ No
	death with the Maryland me 23a or 28a-f show Fraust by notified at	Jre	10e. Street and Number			10f. Zip Code			10g. Citizen o		try?
	ath w 23a	rail	6204 Mossway				212			JSA	
	be filed within 72 hours after death with the Maryla tal Hygiens at all and 1288-1 show do there than "natural", or items 23s or 288-1 show event, the Medical Examinat nast by multiped at	by Funeral Director	11. Marital Status  1 Never Married Warried  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1.		Was Decedent of Hi fYes, specify Cuba I□Yes 2XXNo	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. R B	ace - America lack, White, e city:	
9-0036	2 hour	edt	15. Decedent's Educa			dent's Usual Occupa			16b. Kind of	Business/Ind	lustry
<u>ე</u>	hin 72 P. In "in	piet	(Specify only highest grade		(Give life. L	kind of work done of OO NOT use retired	during most of wo	rking			,
Z	od with	Completed	Elementary/Secondary (0-12)	Compage (1. 10, 01)	Sale	sman			Mercha		ıg
land	S should be filed and Mental Hygi Is marked other aumatic event, II	To Be (	17. Father's Name (First, Middle, Last)  Lawrence Grover Lee	2				me (First, Middle, Crina Tre		•	
Mar	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type Dorothy Virginia Le		19b. Mailir 6204	ng Address <i>(Street a</i> MOSSW <b>ay</b> ,	and Number or Ri Baltimor	oral Route Number e, Maryl	r, City or Ton and 21	m, State, Zip 212	Code)
ē.	es 1 a of Hei of Hei fitem rothe	ľ	20a. Method of Disposition	0.0	ace of Dispo metery, cren	sition (Name of natory or other plac	θ)	Date	20c. Location	n - City or To	wn, State
Ĕ	Pag ment ant: I		4 Donation 5 Other (Specify)	Dular	•	ley Memoria			Timoni		
Baitimor	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Lense	en Konaku		Name and Addres	6500 Y	ork Road B	altimore		
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.	Do not ent			c or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Prog	xw	e De	chne			2	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	-					
		er	Sequentially list conditions, if any, leading to immediate	Due to for as a consequ	ance on:	٩					
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Comm	000	Water	Di	seare			
Ď.	exectant and rial-tra	Еха	resulting in death) Last	Due to (or as a consequ	ence of		-				
Q/90	certificate be executed nding physician and use as the burial-transit	dical	d.	Da	bele	>					
Ŏ	ertifica ling pl	Med	IF FEMALE:	a Maria automa at assess							
O. BOX	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	<ul> <li>c. If yes, outcome of pregnar</li> <li>1 □ Live birth 2 □ Fetal</li> <li>4 □ Pregnant at time of de</li> <li>9 □ Unknown</li> </ul>	death 3□	Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year
as, r.	Se us	by	Part II. Other significant conditions cont	ributing to death but not resu	iting in the ur	nderlying cause give	en in Part I.		bacco use co ′es 2 □ No		e cause of death?
Hecord	> 0 70	Completed						24a. Was	an 24t	o. Were autor	esy findings available
	0 5 0	dwo						autop	med?	pnor to con death? 1  Yes	esy findings available inpletion of cause of
VITA	sician: Th certificete rector, pag	ø	25. Was case referred to medical	8/			26. Place of De	ath (Check only o		1 1 105	Z   NO
o	× 5 5	To B	examiner? 1 Yes 2 No	spital: 1 Mnpatient 2 E	R/Outpatien	t 3□ DOA Othe	er: 4 🗆 Nursing l	Home 5 ☐ Resid	ence 6 🗆 C	Other (Specify	)
	ing After Une		27. Manny of Death 1 ✓ Atural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	vat ∢? Yes 2 ∐ No	28d. Describe h	ow injury occ	urred	
DIVISION		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, str	eet, factory, office		28f. Location (S City or Tow		nber or Rurai	Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	cian: To the best of my know er: On the basis of examinati and manner stated.	rledge, death on and/or inv	n occurred at the time vestigation, in my of	ne, date and place pinion, death occi	e, and due to the ourred at the time,	cause(s) and r date and place	manner as sta e, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, L	Day, Year)
)	0				Mo		31490	1	4/2	106	
*	7 '		30. Name and address of person who com	17	23a) (Type,	Print)	tiv C+	Callo	500	DAL	TIMORE
	Sta	te	31. Date filed (Month, Day, 1949) 9 8		ле Ж	Scarle	11. 2]	ann.	, , ,		mp21281
	Registr		MTT 6 0	2005. Registrar's Signat	800						

State of Maryland / Department of Health and Mental Hygiene 🗍 🗍 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month ABRAHAM LYNN **Physician** 2006 24 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** BALTI I MORE
If Under 24 Hrs. 705 of Birth 7. Age last birthday If Under Year 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours M 2□F Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21 Completed by Funeral 12 Was Deceden Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DOTAT use retired) 16b. Kind of Business/Industry f Health and Mental Hygiene. Coffege (1-4or 5+) s Name (First, Middle, ther's Name (First, Middle, Maiden Sumame) Be P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Method of Disposition Date 20c. Location - City or Town, State 0 Burial 2 Cremation 3 Removal from State 0 permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Facility 22 Name and Address of 21. Signature of Funeral Sen Stricker St. 21223 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Due to (or as a consequence of disease or condition resulting in death) 4041 /Medical Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that intilated events resulting in death) Last eculter Examiner law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): physician Physician/Medical attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No P.O. the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes No certificate 2 No 1 Yes 1 Yes Division of Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 No 2 ER/Outpatient 2 1 Tes 3 DOA Sin funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident completely filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 0053722 who completed cause of death (Item 23a) (Type, Print GOOD CAMARITAN 31. Date filed (Month, Day, Year) 32 Begistrar's Signature State Registrar

			For State Registrar	State of Maryland		rtment of H		Re	g. No.	6 13373
ı	Physici	an	1. Decedent's Name (First, Middle, Last) Adele I. Linsk:	i				2. Date of Death	Day	Year Zoolo 2306 PM
	/Medio Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or	Location of Death	ripri	4c. County	
			St. agnes 1	tospital		Bal	<i>timore</i>			N/A
	Funeral Director		5. Social Security Number 6. Sex 219−10−6277	7. Age (In yrs. las M 251 82	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
			Usual Residence of Decedent					2/26/	1924	MD
	show	7	MD 10b. County	N/A	Town or Lo	ation ltimore				10d. Inside City Limits 1X Yes 2 □ No
	the N	rect	10e. Street and Number			10f. Zip Code		10	0g. Citizen of V	712
	h with	al Di	600 Light Stree	et, Apt 526			2123	30		USA
ω.	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene Item 27 is marked other then "natural", or items 23a or 28s-f show other traumatic event, the Madical Exemination must be multified at	Funeral Director	11. Marital Status 1 1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?     □ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	į į		ispanic Origin? (Spi n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.
21215-0036	ural', c	d by	3 ∏Widowed 4 □ Divorced	If Yes, Give Year or Dates:		☐ Yes 2/€1/No	Specify:		Specify	will ce
15-(	n 72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	ent's Usual Occup kind of work done o OO NOT use retired	during most of work	ing	16b. Kind of Bu	isiness/Industry
212	filed withi Hygiene. rther then	ome	Elementary/Secondary (0-12)	College (1-4or 5+)		Labor			Manufa	acturing
pug	be filed ntal Hygid od other svsnt, ti	Be	17. Father's Name (First, Middle, Last) William H. Rice	ē			18. Mother's Name		Maiden Surnam	re)
Maryland	2 should be f and Mental h is marked of aumatic svs	2	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or Rura		City or Town,	State, Zip Code)
	1 and 2 Health ar tem 27 is		Thomas B. Linsl	ki / Son	407	East C	lement S	St., Ba	ltimor	re MD 21230
ore	ges 1 ar t of Hea if item or other		20a. Method of Disposition 12∑Yurial 2 ☐ Cremation 3 ☐ Re	emoval from State	netery, cren	sition (Name of natory or other place	Θ)			City or Town, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		4 □Donation 5 □Other (Specify)  21. Signature of Euneral Service License				metery 2			ltimore MD
Ba	Depa Impo eny i		21. Signature of Euneral Service License	> D	οα _{•C}	harles : 501 Eas	L. Steve t Fort A	ens Fun Venue.	eral H Balti	Home, Inc.
			shock, or heart failure. List only on		Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pheumonia						10 days
	Examiner			Due to (or as a conseque	nce of):					,
	D iii	iner	Sequentially list conditions, I any, leading to in modulate cause. Enter Underlying Cause (Disease or injury	Due t∂ (cras a nonsecue	noa of):					
	xecute and	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					
8760,	ate be executed hysicien and the burial-transit	icai E	d							
9	artifica ing ph e as th		IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand  1 ☐ Live birth 2 ☐ Fetal d  4 ☐ Pregnant at time of dea  9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Dai Mo	e of delivery nth Day Year
	es that igned b	by Pt	Part II. Other significant conditions con	<del>-</del>	ing in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use cont	ribute to the cause of death?
ord	v require been sig should b	ted	Atrial Hibrilla		-			1 □ Ye	s 20 No	3 Probably 4 Unknown
Records,	The law rite has be	Completed	Chronic obstruct	tive pulmonar	y d	iseuse		24a. Was ar autops perform 1 Yes 2	y ned?	Were autopsy findings available prior to completion of cause of death?
Vital	Physician: The l this certificate har ral director, page	Be C	25. Was case referred to medical examiner?				26. Place of Deat			
of \	Physic this o	မ	1 ☐ Yes 2 💢 No H	-	R/Outpatien		4   Nuising no	me 5 Reside		
	Attending I ir death. ector: After by the funer	ation	1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □No	28d. Describe ho	w injury occur	ed
Division	I or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Numb , State)	er or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th Rempletely filled in by the funeral	edicai Ce	29a. Certifier 1 Certifying Phys	ician: To the best of my knowler: On the basis of examination	edge, death	occurred at the tin	ne, date and place,	and due to the ca	tuse(s) and ma	anner as stated.
	thin 24 or the F	Medi	29b. Signature and title of certifier	and manner stated.		29c. Licens				d (Month, Day, Year)
	F3F8		13-02hn	, MD				1		4,2006
	0'		30. Name and address of person who con		A	Print)	95:11 imore,		1229	
	Sta	ite	ZHW, Zezin 31. Date filed (Month, Oay, Year)	32. Belitrar's Signatu	tvenu	e, ban	1	1000 2	/	
	Regist		APR 2 8 20	106 Bleeves A	K A	artis				
DH	MH 17 Rev 1/2	001		· marin	0					

ORIGINAL

DHMH 17 Rev 1/2001

LINSKI, Adele I

		•	1 - For State Registrar	State of Ma	arylan				ealth a	and Me	-	giene Reg. No.	006	33	74
)	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, L BERNARD  4a. Facility Name (If not institution, g	ANDSM ive street and number)	AN	,			Location o	of Death	2. Date of De Month RPRIL	26 4c. Cd	Sunty of Deat		
	Funeral Director		NORTHWEST HOSPI  5. Social Security Number 216-05-8257  Usual Residence of Decedent		95 (In yrs.	last birthday) Yrs.		r 1 Year	LSTOW If Under Hours		8. Date of Bir Wenth Da	th	LTIMOR 9. Birti	(E hplace (State ountry)	or Foreign MD
	the Maryland 28a-f ahow	rector	10a. State 10b. County  MD BALTIM  10e. Street and Number	ORE	10c. City	BALTI	MORE	ip Code				10g. Citize	n of What Co	10d. Inside C 1  Yes	
36	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or itema 23e or 28e-f ahow do other than "hadical Examinar roust be notified at event, the Madical Examinar roust be notified at	by Funeral Director	130 SLADE AVEN	12. Was Decedent I Armed Forces?	Ever in U.		Was Dec If Yes, sp			gin? (Spec i, Puerto R	ify Yes or No ican, etc.)		U.S Race - Ame Black, White	rican Indian,	
Maryland 21215-0036	filed within 72 hou Hygiene. Ither then "natura ent, the Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed)  College (1-4or 5	+)	life.	kind of w	ual Occupa ork done o use retired	<i>during</i> mosi	t of working	g		of Business/		
ryland	should be filed within nd Mental Hygiene. I merked other than umatic event, the Market was the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merket the Merk	To Be	17. Father's Name (First, Middle, La: HARRY  19a. Informant's Name/Relationship		LAN	DSMAN	no Addre		MINN	ΙE	(First, Middle,		C	OHEN	
	1 and 2: Health ar em 27 ta ther trau		BEATRICE LANDSMA 20a. Method of Disposition	N / WIFE	20b. P		SLAD	E AVE	NUE /		#112-B	ALTIM		D 21208	3
Baltimore,	permit. Pages Department of I Important: If its eny Injury or o		1 Surial 2 Cremation 3 4 Donation 5 Other (Spec	cify)		TIMORE	HEB 2. Name a	REW C	ONG (	y SO	L LEVI	NSON		WN, MD ., INC. , MD 21	
3760,	ate be executed  Wedical  We burial-transit  The burial-transit	licai Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused by one cause on each lir  a	a consequence a consequence	uence of):		A	g, such as			rrest,	sē.	Approximat Interval Bet Onset and I	ween
.O. Box 6	the death certifica y the ettending pr ached for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	⊒Ectopic   ⊒ Other (s	pregnancy				230	d. Date of deli Month	,	/ear
Records, P	The law requires that the de ate has been signed by the e page 2 should be detached f	ρ	Part II. Dther significant conditions	contributing to death be	ut not resu	ulting in the u	inderlying	cause give	en in Part I.			obacco use Yes 2 1		the cause of co	Jnknown
tal Rec	Physician: The law this certificate has b al director, page 2 sl	e Completed	25. Was case referred to medical						26. Place	of Death	24a. Was autor perfo 1 Yes	osy ormed? 2 No	24b. Were au prior to death? 1 ☐ Yes	topsy findings completion of c	available ause of
<b>S</b>	Physician: rthis certified ral director, I	To B	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 🗆	ER/Outpatier	nt 3 🗆 🗅	OA Othe	or.		e 5 ☐ Resid		Other (Spec	eifv)	
<u>_</u>	ing After uner	Certification: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	be On Disease lain	Year)	28b. Time o	М			No 28	3d. Describe f	how injury o	occurred		
DIA	spital or Attend nours after death neral Director: / / filled in by the f		4 Homicide determine	building, etc	of my kno	y) wledge, deat	h occurre	d at the tim	ne, date an	d place, ar	City or Tox	wn, State)	nd manner as	ral Route Num	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29b. Signature and title of certifier)	aminer: On the basis of and manner sta	itea.			n, in my op Oc. License		th occurred			signed (Mont	n, Day, Year)	(
Í	Y		30. Name and address of person wh	o completed cause of d		23a) (Type,	Print)		141		P ME	ATHE		1 7 40	0,
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture	TEK	13	THO	rtcs	TOWN	m	0	21133	

			For State Registrar	State of N	1arylar	nd / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth ar D <i>eath</i>	nd Me		ene)	06	130	375
	Physici	an	Decedent's Name (First, Middle, Lass     CAROLYN LOVING	_							Date of Death Month APRIL 2:	2 , ^{Day} 200	06 Year	3. Time of 2:00	f Death A M
	/Medio	9	4a. Facility Name (If not institution, give		r)		4b. City,	Town, or	Location of				nty of Death	2.00	
			7237 BRIDGEWOOD			In a blink in A		TWOC	D If Under 24	1 Hire o	Data of Bigh		ALTIMO		
Н	Funeral Director		5. Social Security Number 6. Security 11	M 2 1 F /. F	69 (in yrs.	last birthday) Yrs.	Months			Min.	B. Date of Birth Month, Day JULY 27	, 1936	5 9. Birthp	place (State of	-
	<b>D</b>		Usual Residence of Decedent  10a, State 10b, County		10c Cit	ty, Town or Lo	eation							0d. Inside C	ity Limits
	Maryla f ahov	ō	MD. BALTIM	ORE	100. 011		STWO	OD					'		2 X No
	or 28a-	lrect	10e. Street and Number		1		10f. Zip	Code			10		of What Cour	ntry?	
	ath wit	ralD	7237 BRIDGEWOOD D						21224			USA			
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 238 or 288-f ahow other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	? 100		Was Deced If Yes, sped 1 ☐ Yes	city Cubai	spanic Origii n, Mexican, I Specify:	n? (Speci Puerto Ri	ify Yes or No- ican, etc.)		ace - Americ lack, White, cify: WH		
2 2	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	kind of wo	rk done a	lurina most d	of working	7	6b. Kind of	Business/In	dustry	
121	within iene then the Me	Completed	Elementary/Secondary (0-12) 12TH	College (1-40	r 5+)		do not u: TEMAKI		,			OWN	HOME		
Maryland 21215-0036	e filed al Hygi I other vent, I	BeC	17. Father's Name (First, Middle, Last)								First, Middle, M	laiden Sum	ame)		
Z	should be nd Mental marked o	ှ	UNKNOWN	Sun - Object		40b M-115		(Ctroot o			OOMIS  Route Number,	City of Tou	- Ctato Tir	Codel	
N N	and 2 st eatth and n 27 is n		19a. Informant's Name/Relationship (7 WAVERLY LOVING/H				•	,	OOD DR		BALTIMO	,			224
ore,	of Hea	1	20a. Method of Disposition 1 □ Burial 2 🕅 Cremation 3 □	Removal from Stat		Place of Dispo cemetery, crer	sition (Nar	ne of other place		Da			n - City or To		
Baltimore,	permit. Pages Depertment of the important: if Ite any Injury or of		4 ☐ Donation 5 ☐ Other (Specify	)	M	ETRO CI			4	/25/				MARYL	
Ba	permit. Depertrainments Imports any Inju		21. Signature of Funeral Service Licen	see US		(	2. Name ar 5224 ]	EASTI	ERN AV	Е.,	RLES S. BALTIMO	RE, M	ARYLAN	ND 212	24
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	plications that caus one cause on each	ed the deat line.							1		Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approximation of the Approxima	tween
	Physician /Medical		disease or condition resulting in death)	a. Due to for a	s a consec	BR ( quence of):	e Le	WI	ville	M	LADO Z Mil	RSUS	2+	y2	
	Examiner		Sequentially list conditions,	b. Cle	nee	v of	· U	RI	WAR	1	100	Col	2+	- 01	
	rted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consec	quence of):				wit	Z Mals			0	
Ő,	cate be executed physicien and the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or a	as a consec	quence of):			-				1		
8760,	cate b	dlcal		d									-		
Box 6	w requires thet the death certific been signed by the ettending p should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon 1 ☐ Live birth	ne of pregn		⊒Ectopic pi	rennancy					Date of delive	•	
о. В	ne deat the ett hed for	/slcla	in the past 12 months? 1 ☐ Yes 2 ØNo 9 ☐ Unknown	4□ Pregnant 9□ Unknown	at time of o		Other (sp					'	Month	Day	Year
<u>α</u>	thet the	y Ph	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlying o	ause give	en in Part I.		23e. Did tob	acco use co	ontribute to t	he cause of	death?
rds	equires en sign ould be										1 □ Ye	s 2 No	3 ☐ Prot	ably 4 🗆	Unknown
of Vital Records,	: The law requires thet the death certific cate has been signed by the ettending p page 2 should be detached for use as	Completed								_	24a. Was an autopsy perform	248	b. Were auto prior to co death?	psy findings mpletion of c	available cause of
<u>a</u>		e Co	25. Was case referred to medical						26 Place	of Dogsth /		⊠No No	1 🗆 Yes	2 No	
Ž	ysicis	To B	examiner? 1 Yes 2 No	Hospital: 1 🔲 Inpa	tient 2	ER/Outpatier	nt 3 DC	OA Othe	20		e 5 Resider	-	Other (Specia	(y)	
o uc	ling Pt		27. Manner of Death 1 Natural 5 □ Pending		njury Day Year)	28b. Time o Injury		28c. Injury Work			d. Describe ho	w injury occ	urred		
Division	Attending Physician: r death. ector: After this certific by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of	njury - At h	ome, farm, sti	M reet, factor		Yes 2 □Ne		of. Location (Str		mber or Rura	al Route Nun	nber,
ă	spital or A	Cert	4  Homicide determined	building,	etc. (Speci	fy)					City or Town,	, State)			
	24 t 24 t Fu etely	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred vestigation	at the time, in my of	ne, date and pinion, death	place, an occurred	nd due to the ca d at the time, da	use(s) and ite and plac	manner as s e, and due t	tated. o the cause(	s)
	To the within 2	W	29b. Signature and title of certifier					c. License		,			ned (Month,	Day, Year)	
,	61			On				V19	1221	/		4.	26.	06	
	)		30. Name and address of person who	completed cause o	death (Ite	m 23a) (Туре, - 2 З	Print) B. A	200	BA	117	Ma	2/2	2/		
	Sta		31. Date filed (Month, Day, Year)		strar's Sign	ature	ast =				40				
	Regist	elr	run a U Z	100	Post &	O' ASS	THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE P								

FE 920 F		For State Registrar	State of Maryland	/ Depa	artment <i>tificate</i>	of H	ealth and Death	F	Reg. No.	006	1337
Division	A	1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	ith Day	Year	3. Time of Death
Physici /Medic		Mae Elizabeth	Main					April	23	2006	5 38P
Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, T	Town, or	Location of Dea	ith	4c. C	county of Death	
	4 3	Frederick Memo	rial Hospital		Fre	eder	ick			Frederi	ck
Funeral Director		217 37 0170	ex 7. Age (In yrs. las □ M 2  F  67	t birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 Hr Hours Mir		, 193	9. Birth Cou	place (State or Fore intry) yland
3		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Lo	cation						10d. Inside City Lim
ital Hygiene. Id other than "natural", or Items 23a or 28a-f ahow avent, It's Modical Exeminar must be notified at	ector	Maryland Frederi		reder	ick						1 🗆 Yes 💥
23s or 2	at Dire	10e. Street and Number 5905 Bartonsvil	le Road		10f. Zip (	1704			U.S.	en of What Cou .A.	intry?
ES	inel	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decede	ent of His	spanic Origin? (	Specify Yes or No- irto Rican, etc.)	14	<ol> <li>Race - Ameri Black, White</li> </ol>	
ral', or it Exemin	Completed by Funeral Director	1 Never Married XXMarried 3 Widowed 4 Divorced	1 □ Yes XX No If Yes, Give Year or Dates:		I□Yes 🔀		Specify:	,	ŀ	Specify:Whit	
a and and and and and and and and and an	etec	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual kind of work	Occupa k done d	tion uring most of w	orking	16b. Kind	d of Business/Ir	ndustry
P P P	du	Elementary/Secondary (0-12)	College (1-4or 5+)		oo notuse emake				Otar	n Home	
Hygiene. ther than				пош	enake		40. 14. 15. 4. 11.	(C) - 1 (C) - 1			
d d	To Be	17. Father's Name (First, Middle, Last, Ralph Cooley	Lenhart				Ann	ame (First, Middle, nabelle V:	irgir	nia Mero	
= 12 t		David T. Main, hu						ad, Frede:			
nent of Hea int: If Item iry or other		20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Man -	ce of Dispo netery, crem nt Oliv	sition (Naminatory or other	e of her place etery	April 2	Date 27, 2006		ation - City or T lerick,	own, State Maryland
Department of H Important: If Its any injury or of once.	1	21. Signature of Fineral Service Licer	A 1	∠ Ke	. Name and	Address	s of Facility Basford	l PA Fune:	ral F	······································	1701
hysician /Medical xaminer	Examiner	23a. Part t. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. CARD Due to (or as a consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the conseq	nce of):	ANO						Approximate Interval Between Onset and Death
physician and the burial-transit	cal	that initiated events resulting in death) Last	d. CARdiomyo		hy						
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetel de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	Ectopic pre Other (spe				23	3d. Date of delive Month	very Day Year
signed b		Part II. Other significant conditions of	)	ng in the ur	nderlying ca	use give	n in Part I.		bacco us		the cause of death
has been si ge 2 should	Completed by	HyperLipid	*					24a. Was	an sv	24b. Were autoprior to co	opsy findings avail
pate ha	Con	NON ISCH	emic cardio	muo	DATHU	1		perfor	med? 2. No	death?	
certificate rector, pag	Be	25. Was case referred to medical examiner?		2	4		26. Place of De	eath (Check only o	ne)		
dire	2	1 Yes 2√No	Hospital: npatient 2 EF	VOutpatien	t 3 DO	A Othe	r. 4 🗌 Nursing	Home 5 Resid	lence 6	Other (Speci	ify)
r death. ector: After this certification by the funeral director,		27. Manner of Death 15 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	8b. Time of Injury	M 28	Bc. Injury Work	at ? es 2 □ No	28d. Describe h	ow injury	occurred	
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined		e, farm, str	eet, factory,	office		28f. Location (S City or Ton		Number or Rur	ral Route Number,
within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Chack only one)	nysicien: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death n and/or in:	occurred a restigation,	it the tim	e, date and place inion, death occ	ce, and due to the courred at the time,	cause(s) a date and p	ind manner as solace, and due to	stated, to the cause(s)
omp.	Me	29b. Signature and title of certifier			29c.	License	number	1	29d. Date	signed (Month,	, Day, Year)
T		Osm Vitarallo	mo.	0-) T		127	544		4)	2286	
		30. Nam and address of person who	completed cause of death (Item 2 M.D., 180 Thom			Dri	ve. # 2	202 Fred	ericl	z MD 2	1702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Mack Donald Madison Pril 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ABattimore Year If Under 24 Hrs. Hospita Dinai 8. Date of Birth (Month, Day, OCT 3 7. Age (In yrs. last birthday) 63 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** Months Hours 1 3M 2 ☐ F 247-68-0285 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other then "naturel", or items 23s or 28s-f show treumatic event, the Madical Examinar must be natified at N/ABaltimore Yes 2 □ No MD Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21215 5246 Linden Heights Ave USA Mack Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Danko Elementary/Secondary (0-12) 12th t of Health and Mental Hygiene. College (1-4or 5+) Corporation Laborer 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I Known Rosalie Fulton John Madison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5246 Linden Heights Ave Baltimore MD 21215 Clara Madison / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: if ite eny injury or otl once. ₩ Burial 2 Cremation 3 Removal from State 4/29/06 Woodlawn MD Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore MD 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 days Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the ettending physician and detached for use as the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No 9 Unknown 9 Unknown been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>À</u> Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificete has t lirector, page 2 s 1 🗆 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred repital or Attending Prours after death.

neral Director: After t Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES- DOC 30. Name and address of he son who com leted cause of death (Item 23a) (Type, Print) Sinai Hospital Wara Carolyn 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 8 2006 Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 2

32. Régistrar's Signature.

13/18/2

8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🗍 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Konald Edgar Martin April AM 1:10 22,2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rising Sun

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Hours Min. (Month, Day, Year) Cecil Church Rd Ebenezer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 3 M 2 □ F 214-46-3461 60 Yrs May 16, 1945 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Cecil Rising Sun 1 XYes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 256 Ebenezer Church Rd 21911 USA 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Unknown 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Helen Fannon Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 Ebenezer Church Rd Sherri Morris/ Rising Sun, MD Daughter 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 Burial 2 Cremation 3 Removal from State April 22, 2006 Anatomy Gifts Registry Hanover, MD 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 0 7522 Connelley Drive, Suite P Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition Bladder Cancer yeurs resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 es 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

as the burial-transit

been signed by the attending physician and

detached

Be

2

Certification:

icai

State

The law requires that the death certificate be executed

Hospitel or Attending Physician:

ţ

death

this

After t

Director:

within 24 hours a To the Funeral C

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ဂ္

**Funeral** 

Director

in then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

deeth with the Maryland

Pages 1 end 2 should be filed within 72 hours after

marked other then

ant of Health and Mental Hit: If item 27 le marked oth y or other traumatic even

permit. Page Depertment of Important: If eny Injury or page.

Hygiene

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examine Completed by Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

1 ☐ Yes 2 ☑ No 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/OutpatienI 28a. Date of Injury (Month, Day Year) 5 Pending investigation

3 DOA 28c. Injury al Work? 28b. Time of 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Natural 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

28d. Describe how injury occurred

2 No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

erdner W

De044313

Rising Sun, MD 21911

04/24/ 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Colonial Way Joseph K. Weidner, Jr. M.D.

31. Date filed (Month, Day, Year) APR 2 8 2! 8

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

		1	For State Registrar	State of Mai		artment of rtificate o		Mental Hygie	Em U U	6   3380
			Decedent's Name (First, Middle, Last	)				2. Date of Death	Day +	3. Time of Death
	Physicia	ın			ohn	ľ	ullins	Month .	1971	2006 11:42 AM
	/Medic		Clifton 4a. Facility Name (If not institution, give		Onn		, or Location of Dea	th	4c. County	of Death
,	Examin		Union Memorial			Balti	more			
	5		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Ye		8. Date of Birth	005	9. Birthplace (State or Foreign
	Funeral Director			ДМ 2□F	88 Yrs.	Months Day	rs Hours Min	. (Month, Day, You 21	17	Country) VA
			Usual Residence of Decedent							
	yłanc zow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar Mar	ţ	MD NA		Baltimo	re				XXYes 2□No
	r 28s	<u>e</u>	10e. Street and Number			10f. Zip Cod		10g		Vhat Country?
	38 o	=	2638 Ridgely St	creet			21230		U.	S.A.
	daath with tha Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Example Forces?	ver in U.S. 13.	Was Decedent	of Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No-		e - American Indian, k, White, etc.
٥	aftar or Ita	교	1 Never Married 2 Married	1 XYes 2 No		1 ☐ Yes 2 🔯 1			Specify	4
2-003e	72 hours aftar natural', or Ite	þ	3 Widowed 4 Divorced	Year or Dates:						втаск
r C	72 h	etec	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Oc kind of work do	ne during most of w		b. Kind of Bu	usiness/Industry
7	thin ta.	d	Elementary/Secondary (0-12)	College (1-4or 5+	.)	aborer	irea)		City	of Baltimore
N	e filad within 7 at Hygiana.	Completed	4th grade	na		aborer	19 Mother's No	ame (First, Middle, Ma		
פ		Be	17. Father's Name (First, Middle, Last)					e Scott	iden Juman.	16)
<u>X</u>		2	John Mullins				3 3 3 3 3		- T	Character Time Conde
100	C1 10 - 00		19a. Informant's Name/Relationship (7					Rural Route Number, C		ck, Md 21163
≥	and aalth m 27	1	Craig D. Mullin	s-son						City or Town, State
ore	permit. Pagas 1 an Dapartmant of Haal Important: If Itam 2 eny injury or other once.	1	20a. Method of Disposition 1	Removal from State	1	matory or other	olace)			
Ě	Pag nant ant: I		4 ☐ Donation 5 ☐ Other (Specify		Crownsv		and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	5/06 C	rowns	ville, Md
altimore,	portrupy in y	1	21. Signature of Funeral Service Licen	see ///	M.	2. Name and Adarch F	dress of Facility H West			
m	8° E ≥ 9	100	Trette	Kyme	4	300 Wa	oash Ave	, Baltim		
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caused one cause on each line	the death. Do not en	ter the mode of	dying, such as cardi	ac or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Post		Cont	Jin.			Onset and Death
	/Medical		resulting in death)	a Due to (or as a	consequence of):					
Н	Examiner			. SeA	5/3					
	1000	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C						
<u>,</u>	axac n an	Exa	resulting in death) Last	Due to (or as a	consequence of):					
760,	Attending Physicien: The law requires that the death certificate be axecuted rideath.  sctor: After this cartificate has been signed by the attending physicien and both the funeral director, page 2 should be detached for use as the burial-transit		(	d						
68	ificat g ph) as th	Physician/Medical								
ŏ	aath certific attanding p for usa as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		□Ectopic pregn	ancy			te of delivery
P.O. Box	daatt a atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Other (specif)			Mid	onth Day Year
0	that tha da led by tha a datached	hys	9 ☐ Unknown	9□ Unknown						
_	uires that signed t id ba dat	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause	given in Part I.	23e. Did toba	icco use con	tribute to the cause of death?
g	luire n sig							1 ☐ Yes	2 🖪 No	3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	w raquin baan si should	Completed						24a. Was an	24b.	Were autopsy findings available
Re	ha lav a has iga 2	E C						autopsy perform	ed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ā	ician: Th cartificata ractor, pag	ပိ	25. Was case referred to medical				26 Place of D	1 Yes 2		10165 2010
⋚	carti	00	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	ant 3[] DOA	Other	Home 5 ☐ Residen		ner (Specify)
o	Phys rthis raldi	15	27. Manner of Death	28a. Date of Injur (Month, Da)			njury at	28d. Describe how		
L _O	ding F Aftar funer	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		Year) Injury	м	Work? 1 ∐ Yes 2 ∐ No			
<u></u>	daat daat ctor: y tha	lca	3 Suicide 6 Could not b	e 28e. Place of Inju	ury - At home, farm, s	treet, factory, of	ice			ber or Rural Route Number,
<u> </u>	aftar Dire	Certification:	4 Homicide	building, etc	c."(Specify)			City or Town,	State)	
_	To the Hospital or Attending Physician: Tha within 24 hours after death. To the Funeral Director: After this cartificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying PI	ysician: To the best	of my knowledge, dea	ath occurred at the	ne time, date and pla	ace, and due to the cau	use(s) and m	anner as stated.
	Hos 24 h Fur ataly	edical	(Check only 2 Medical Example)	ninar: On the basis of and manner sta	examination and/or	nvestigation, in	my opinion, death or	ccurred at the time, da	te and place,	and due to the cause(s)
	To the within 2 To the complain	₹ S	29b. Signature and fille of certifier	11		29c. Li	cense number	29	d. Date signe	ed (Month, Day, Year)
<b>\</b>	r ≤ F ŏ		Webs to	A no		D	005353	9	April	19th 2006
	41		30. Name and address of person who		eath (Item 23a) (Tyro				7	114 7000
9	20		So. Name and address of person who	Dia III And	) Done	3539	Union	Memoria	110	Spital
		210	31. Date filed (Month, Day, Year)	32 Tegistra	ar's Signature	0 00/	U-11-1	,		-1:100
	St Regist	ate rar		006	A A	ande)				
	7			July Charles		W-100				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year April 14:20 PM Street Murrell Dorethea 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinay Baltimere City Hespita. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Year) 30 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 05 12 Birthplace (State or Foreign Country)
 MD **Funeral** 1□M 25F Director 75 215-28-4409 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 2309 Anoka Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 X No Il Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2 € No Specify: Be Completed by Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cashier Supermarket 10th grade na anould be filt.

Ith and Mental Hye.

7 to mark-Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Gustis Fred Street 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Heelth a James_Murrell-Husband 2309 Anoka Ave, Baltimore, Md Itimore, .. Pages 1 r 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Description | 2 □ Cremation | 3 □ Removal from State | 4 □ Donation | 5 □ Other (Specify) 4/28/06 Baltimore Co, Md Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mpc. March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician de /Medical Due to (or as a consequence of): Examiner Edemo Sequentially list conditions, lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed use as the burial-transit and Due to (or as a consequence of). physician Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Year 4☐Pregnant at time of death Day 5 Other (specify) the o 9 Unknown ģ ۵. signed I Part II. Other significant conditions contributing to death but not resulting if the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? δ Division of Vital Records, 99 2 🗹 No page 2 should Be Completed 1 🗌 Yes 3 Probably 4 Unknown peen 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☑ No 2 No 1 Yes Physicien: funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? 1 ☐ Yes 2 ☑ No 1 Dinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: / 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SACIF ain 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospi'ta ALI, LANKARYNI CM Sinai 31. Date filed (Month, Day, Year) 32. gistrar's Signature State Registrar

			1 - State of Maryland / Department of Heal Registrar Certificate of Dea	Ith and Me	ental Hygie	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	13382
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  ElMer Gray McIver		2. Date of Death Month	Day Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and umber)  4b. City, Town, or Loca  Good Someriton (1859) for BALTIN.			4c. County of Death	
	Funeral Director	2	37-44-8594 1XM 20 F 73 Yrs. Months Days Ho	Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, You 7-/0-3	ear) (secou	place (State or Foreign ntry) Wh Carolina
	Aaryland f ehow	or	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location			-	10d. Inside City Limits 1 Yes 2 □ No
	death with the Maryland ma 23a or 28s-f ehow Linual be codified at	Director	Baltimore  100. Street and Number  100. Zip Code  100. Zip Code	2.0	10g.	. Citizen of What Cou	
JEK	5-0036 72 hours after death with the M "natural", or itema 23a or 28a-f	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes No If Yes, Give Year or Dates:	Dic Origin? (Spec exican, Puerto R pecify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	zan Indian, etc.
ELMER		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementa y/Sedorbary (0-12)  Coflege (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during (Jife 10 DNO) Se religion	g most of working YD	j 161	b. Kind of Business/In	dustry
	Maryland 212. Id 2 should be filed within the and Mental Hygiene. Z7 is marked other then traumatic event, the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the	To Be C	17. Father's Name (First, Middle, Last)  Ed MC Ivek	Mother's Name (	First, Middle, Mai	alas	J
WER	Mark a 27 list a 17.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N  Darlene R. Williams (Daughter)  2604 Wend		Route Number C	it) or Town, State, Zin	Code)21234 Le MD
121	Pag Pag nent ant: I		20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)  4 Donation 5 Other (Specify)	ardens		Location - City or To	own/State
>	Balt permit. Departi Import any inj		21. Signature of Funeral Service Licensee	Factories Contract	se Fun	eral Ser	vias
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A Renal failure	ch as cardiac or	respiratory arrest,		Approximate fnterval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence off)	fectio	7		
	8760, cate be executed by sician and the burial-transit	dical Examiner	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	**			
	Division of Vital Records, P.O. Box 68760, within 24 hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   Yes 2 ☐ No 9 ☐ Unknown   Yes 2 ☐ No 9 ☐ Unknown   Yes 2 ☐ No 9 ☐ Unknown   Yes 2 ☐ No 9 ☐ Unknown   Yes 2 ☐ No 9 ☐ Unknown   Yes 3 ☐ Ectopic pregnancy   Yes 3 ☐ Ectopic pregnancy   Yes 4 ☐ Pregnant at time of death   Yes 3 ☐ Ectopic pregnancy   Yes 3 ☐ Ectopic pregnancy   Yes 4 ☐ Pregnant at time of death   Yes 3 ☐ Ectopic pregnancy   Yes 4 ☐ Pregnant at time of death   Yes 3 ☐ Ectopic pregnancy   Yes 4 ☐ Pregnant at time of death   Yes 3 ☐ Ectopic pregnancy   Yes 3 ☐ Ectopic pregnancy   Yes 4 ☐ Pregnant at time of death   Yes 3 ☐ Ectopic pregnancy   Yes 4 ☐ Pregnant at time of death   Yes 4 ☐ Yes 4 ☐ Yes 5 ☐ Other (Specify) ☐ Yes 4 ☐ Yes 4 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐ Yes 6 ☐			23d. Date of delive	ery Day Year
	rds, P quires that n signed t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F  Meter Static Phostate (ance)	Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
	Division of Vital Records, to attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be compared.	Completed	Thyrord cances		24a. Was an autopsy performed	24b. Were auto prior to co death?	psy findings available impletion of cause of
	Vital Fidelian: The certificate	BeC		Place of Death (	1 ☐ Yes 2 ☑ Check only one)	No 1 ☐ Yes	2□ No
	Of V Physic this ce al dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 [			e 6 ⊡Other (Specif	v)
	Vite funeral	Certification:	27. Manner of Death  1 🖹 Natural 5 Dending investigation  3 Suicide 6 Could not be		d. Describe how i	n _f ury occurred	
	Divis To the Hospital or Atte within 24 hours after de To the Funeral Director completely filled in by th	Certifi	4 Homicide determined building, etc. (Specify)		City or Town, S		
	he Hosp in 24 hou he Fune pletely fil	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, dat a control of the basis of examination and/or investigation, in my opinion, and manner stated.	ate and place, and, death occurred	d due to the cause at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
	To T	2	29b. Signature and title of certifier NI) PSh TEAS MD RES C			Date signed (Month, PRIL 22 nd)	
	15			)LEVARD	, BALTI	more, mar	JUMD 21239
	Sta Registi		31. Date filed (Month, Day, Year)  32. Rigistrar's Signature  APR 2 8 2006				

Decided Parks   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   March   Price   Price   March   Price   Price   March   Price   Price   Price   Price   Price   Price   Price   Price   Price   Price   Price   Price   Price   Price   Price   Price   Price   Pric				For State Registrar	State of Marylan	-	irtment of H			iene	3383	
Margaret Winifred O'Neill  Families  Families  Filtered  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Care Center  Charlestown Ca		0							2. Date of Deat	h		_
The first part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of				Margaret Winifr	ed O'Neill						6:00 A.M	
Social Social Control Pumber   6. size   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1.00 months   1	N.						4b. City, Town, or	Location of Death				
169-10-4562   100   200   100   200   100   200   100   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   20				Charlestown Car	e Center							
Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses a location of December   Uses				10	IM 25FE	**			(Month, Day,	Year) 1915 I	). Birthplace (State or Foreign Country) Pennsylvania	ł
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street		P.		Usual Residence of Decedent								_
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street		arylar show	_									
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street		8a-f	cto		ore Ca	tonsvi	1					
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street		with t	吉		I and #0C10			00	1		at Country?	
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street		eath	era			S. 13.V			pecify Yes or No-		- American Indian.	_
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street	36	rs after d i', or Iten		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	1	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black,	White, etc.	
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street	9	2 hou	ed	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Busi	ness/Industry	_
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street	215	hin 7.	ple			(Give life. I	kind of work done o OO NOT use retired	during most of worl  )	king			
John C. Flaherty   19th Informatic Name State   19th   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor, Officer of Namehor, Age Control   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Namehor of Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Anderson Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street and Plaus Results Namehor)   19th Maining Address (Street	2	ad wit	Сощ	12		Admin	istrative	Assista	int S	St. Char	les Seminary	
Physician Medical Examiner    Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projec	n	be file tal Hy d oth	Be								j.	
Physician Medical Examiner    Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projec	₹	Men Men Marke Matic	ို									_
Physician Medical Examiner    Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projec	Mar	12 sh h and 7 is n treun					-			-		
Physician Medical Examiner    Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projec		1 and Heall em 2		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of					-
Physician Medical Examiner    Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projec	ē	ages ant of t: If it			emoval from State I				2006 C	atonsvil	lle, Marvland	
Physician Medical Examiner    Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projection Medical Examiner   Projec	፟	artme orten injur	1		99	22	. Name and Addres					-
Prysician Miscolar Cause (Final Legisland Control Institute Cause on each line.  Prysician Miscolar Cause (Final Legisland Control Institute Cause on each line.  Prysician Miscolar Cause (Final Legisland Control Institute Cause on each line.  Prysician Miscolar Cause (Final Legisland Control Institute Cause on each line.  Prysician Miscolar Cause (Final Legisland Control Institute Cause on each line.  Prysician Miscolar Cause (Final Legisland Control Institute Cause on each line.  Prysician Miscolar Cause (Final Legisland Control Institute Cause on each line.  Prysician Miscolar Cause (Final Legisland Control Institute Cause on each line.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due	ñ	Per Dep		· dobece	n Sp	16	Funeral H 30 Edmond	Home of C Ison Aven	atonsvil ue: Cato	le,Inc. nsville.	MD 21228	
Proyection Medical Examiner  Sequential is conditions  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a		14.		23a. Part1. Enter the disease or compli	cations that caused the death						Approximate	
Due to (or as a consequence of):	1	Pnysician `	3	Immediate Cause (Final		10191	y hy	meters	'un			
Due to (or as a consequence of):    Substitute   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control		/Medical			Due to (or as a conseq	uence of):		-				_
State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  State  St		⊏xaminer		Sequentially list conditions,	o							_
FFEMALE:   236. Mas decedent pregnant in the past 12 mornths?   1   1   1   1   1   1   1   1   1		ed sit	lne	causa. Entai Underlying	Due to (or as a consequence	uence of):					-7	
FFEMALE:   236. Mas decedent pregnant in the past 12 mornths?   1   1   1   1   1   1   1   1   1		and and il-tran	хап	that initiated events	Due to (or as a conseq	uence of):						_
FFEMALE:   236. Mas decedent pregnant in the past 12 mornths?   1   1   1   1   1   1   1   1   1	9	sician buria	al E									
1   Yes   2   Mo   3   Probably   4   Unknown   24a. What an autopsy findings available prior to completion of cause of geath?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   26. Place of Death (Check only one)   27. Manner of Death   1   28. Deate of Injury   28b. Time of Injury   28b. Time of Injury   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe h	687	ificate g phy: as the										_
1   Yes   2   Mo   3   Probably   4   Unknown   24a. What an autopsy findings available prior to completion of cause of geath?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   26. Place of Death (Check only one)   27. Manner of Death   1   28. Deate of Injury   28b. Time of Injury   28b. Time of Injury   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe h	ŏ	anding use	ZW.				Cotonio prognanov			23d. Date	of delivery	
1   Yes   2   Mo   3   Probably   4   Unknown   24a. What an autopsy findings available prior to completion of cause of geath?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   26. Place of Death (Check only one)   27. Manner of Death   1   28. Deate of Injury   28b. Time of Injury   28b. Time of Injury   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe h	m m	death	sicia	1 ☐ Yes 2 🕱 No	4☐Pregnant at time of d					Month	1 Day Year	
1   Yes   2   Mo   3   Probably   4   Unknown   24a. What an autopsy findings available prior to completion of cause of geath?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   25. Was case referred to medical examiner?   1   Yes   2   No   26. Place of Death (Check only one)   27. Manner of Death   1   28. Deate of Injury   28b. Time of Injury   28b. Time of Injury   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe how injury occurred   28b. Describe h	o.	at the by the	Phys		1-1811				1			
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1		res th ignec be de		Part II. Other significant conditions cor	ntributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.				
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1	ord	requi	eted							,	Probably 4Onknown	
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1	ec	has b	nple						autops	y prio	or to completion of cause of	
A designation of Death    State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat		the The							1□ Yes 2	1 No 1		_
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 2	<u> </u>	sicien certif rector	00	examiner?	lospital:	ED/0	Othe	-				
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 2	ot	Physic this aral di		_		28b. Time of	I JUDA	4 Mulsing I				-
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 2	on	nding th. :: Afte e fune	tlor		(Month, Day Year)	Injury						
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Certifier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 20c. Carrier 2	Oivis	or Atter after des Director	ertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number , State)	or Rural Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  The Care Care Care Care Care Care Care Car		Hospite 4 hours Funeral		(Check only 2 Medical Examin	ner: On the basis of examina	wledge, death tion and/or inv	occurred at the tim restigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mann ate and place, and	er as stated. d due to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  The Care Care Care Care Care Care Care Car		o the o the omple	Mec		and manner stated.		29c. License	number,	25	d. Date signed (	Month, Day, Year)	-
State 31. Date filed (Month, Day, Year) 32. Figistrar's Signature		- s + ŏ		1/1/	MD		DY	744)	6	Jac 1 2	6 2006	
State 31. Date filed (Month, Day, Year) 32. Febistrar's Signature		in		30. Name and address of person who co	empleted cause of death (Item		1 /	hoice (	anu (	gtons.	rile dule	
	:			0.00	29		certi	- 1 - 6				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Katrina Denise Powe

		- For State Registrar		,		Certifi	cate of	Deatl	h				Reg. N	vo. 20		- drawner	0381
Physician ledical Examine	1	1. Decedent's Name (First, Mi Katrina	ddle,Last)	P	owe							2. Date of Month <b>April 2</b>	Death Da 3, 2006	6	r	3. Time o	
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Forestville							Death			4c. County of Prince G		s				
Funeral Director		5. Social Security Number 046–64–6089		м 2 ^X F	7. Age (In	-	oirthday) Yrs.	Months	er 1 Year s Days	If Under Hours	1.60	1	,	1974	9 Birth Foreign Cour		SC
daryland 28a-f show any d at once.		Usual Residence of Decedent 10a. State 10b. Cour  MD Prin 10e. Street and Number	ty	eorge'			vn or Locati						100.0	Citizen of Wh		1Y	de City Limits
with the Maryland ns 23a or 28a-f sho be notified at once.		3733 Done 11 I	rive	12. Was De	cedent Eve	er in U.S.		s Decede	207	anic Drigir			or No-	SA 14. Race	- America		ı, Black,
s afte	6 2 -			Armed F  1 Yes f Yes, Give Ye or Dates:	2 <u>X</u>			Yes 2	X No					Specify:	B1a		
15-0036 Titled within 72 hour Hygiene d other than "natu the Medical Exar	Completed	Elementary/Secondary (0-1			1-4 or 5+)	led) 10	during mo		king life. [	DO NOT u				Hotel		dustry	
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	å	17. Father's Name (First, Mid- Samuel Woodro 19a. Informant's Name/Relatio	ow Br				19b Mailing	Address		Eloi	se 1	licky	Pow	len Surname 7 <b>e</b> City or Tow		Zin Code	3)
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event.		Eloise Vicky 20a Method of Disposition	Powe	(Mc	ther)	)   20b. Plac	-	Huge	er St	t. Ch	erav		295				
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is narked of injury or other tranumatic event, if	-	1 X Burial 2 Crema 4 Donation 5 Other 21. Signature of Funeral Serv	Specify:		rom State		dry H	ill (	Cemet	tery of Facility neral		3-06	C	Cheraw	, SC		
m 링크트로 Physician /Medical	1	23a. Part 1. Enter the disease failure. List only one cal	ise on eac				not enter th	08 Ke	ersha	aw St	. Cl	nerav		Shock, or hea			imate Interval en Onset and Death
Examiner		Immediate Cause (Final dise or condition resulting in death Sequentially list conditions,	n) D	ue to (or as	a conseque	ence of):	bree rije										
ed .	틹	if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death). La	d c	ue to (or as													
execut an and al - tra	- dical	UNPENDED	d	AMENDED										204 Data of	ala E a a		
100	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1		23c. If yes, 1 Live 4 Preg 9 Unkr	birth nant at time		2 Fe	tal death ner (Spec		Ectopic _I	pregnan	су		23d. Date of Month		ау	Year
IS, P.O.   quires that the en signed by t	S	Part II. Other significant cor	ditions	contributing 1	to death bu	t not resul	ting in the u	nderlying	cause giv	ven in Part	t I.	1	_	No 3	Proba	bly 4	
Division of Vital Records, rat or Attending Physician: The law requiring after death.  "A Director: After this certificate has been subject in by the funeral director, page 2 should be a present the funeral director, page 2 should be a present the funeral director.	Completed	25. Was case referred to med	lical						96 Place (	of Death (C	Check o	1 🗸	autopsy performed Yes 2	<u>d</u> ?		mpletion	of cause of
Vital ysician his cert	e Re	examiner?		ospital: 1	Inpatient	2 ER	/Outpatient			Othor:		Home :	5 Res	sidence 6	✓ Other.	Scene	
sion of Vital F the death. The this certification of the this certification, yether this certification, when the this certification, we have a second of the this certification.	-1	27. Manner of Death  1 Natural 5 F	ending nvestigation	FOUNI Apr 23,		F(	b. Time of I DUND: 030 hrs		1 Y	yat Work? es 2 ✔ t	No S	Subject	assaul				
hou hou	al Certification:	4 Homicide	etermined	e (Specify	Resid	ence	e, farm, stree				3	or To	wn, State nnell [	et and Number Prive, Dist	rict Hei	ghts, N	
To the Howithin 24 F. To the Fur	Medical	one) 2 Medical I	Examiner:		of examina			ion, in my	opinion,	death occi							)
	Σ	29b Signature and title of cel	lion	rill	-Pa	lle	S	290	O.C.N					od Date signi pril 24, 20		th, Day,Y	ear)
5		30. Name and address of per Patricia Arpnica-Po	llak MD	. Assis	tant Med	lical Ex		111 P	enn Str	eet, Bal	ltimpre	, MD 2	1201				
Sta Registr	ar	31. Date filed (Month, Day, Ye		903	leģistrar's	A. C.	Mar	1									
DHMH 17 Rev 1/20	01			60		(	DRĪGINA	L									

State of Maryland / Department of Health and Mental Hygiene

1. Decederate Name (Fruit Months) (Appell 2) 2. Decederate Name (Fruit Months) (Appell 2) 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415 2. 2006 415						Certificate	e of Death	,	Reg. No.	10 1	9.00
MARY LOUISE PEGRAM  April 25, 2006 (4:15  Frammer of the method power water durative)  Frammer of Search method power water durative)  Frammer of Search method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power of the method power			1. Decedent's Name (First, Middle, La	st)				2. Dete of De	ath		3. Time of Dea
Examiner  Fundamental Control (Memorical International Control (Memorical International Control (Memorical International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control International Control Int			MARY	LOUI	SE	PEGRA	M			006	4:15 AM
5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security  10 M 2007  8. Social Security  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2007  10 M 2			4e. Fecility Name (If not institution, giv	e street end number)			4b. City, Town, or	Location of Death	4c. County	of Deeth	
Districtor   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100											
Do. Sies   100. County   100. Chy, Town or Location   101/26   102/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   103/26   1			579-26-1489			Months		8. Date of Bin (Month, De December	h y, Yeer) 18, 1924	9. Birthplac Country, Washir	e (State or For ngton ,
Physician Medical Examiner  Physician Medical Examiner  To go you have been a consequence of:  Sequentially list conditions, and the sequence of:  Sequentially list condition	faryland abow	ا ا	10a. Stete 10b. County		0c. City, Tov	vn or Location	- 1 Cl 3 3			10d.	Inside City Lir
Physician / Medical Examiner    Part   Standard   Properties   Section   Part   Properties   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Part   Properties   Part   Part   Properties   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Par	the N	ect.		erset		10f 7in			10a Citizen of V	Vhet Country	2
Physician Medical Examiner  The property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of th	with with					1011 1019			-	-	
Physician Medical Examiner  The property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of th	death	Jera		12. Wes Decedent Ev	er in U,S.	13. Was Deced		Specify Yes or No		e - American	
Physician Medical Examiner  The property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of th	urs after of the fearth or item	þ	1 Never Married 2 X Merried	1 ☐ Yes 2XXVo				to Rican, etc.)			
Physician / Medical Examiner    Part   Standard   Properties   Section   Part   Properties   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Part   Properties   Part   Part   Properties   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Par	Natur	ted	15. Decedent's Ed	fucation	166	Decedent's Usue	Occupation	rkina	16b. Kind of Bu	siness/Indus	try
Physician / Medical Examiner    Part   Standard   Properties   Section   Part   Properties   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Part   Properties   Part   Part   Properties   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Par	File in it	l du				life. DO NOT us	e retired)	rking			
Physician / Medical Examiner    Part   Standard   Properties   Section   Part   Properties   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Part   Properties   Part   Part   Properties   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Par	ed w ygien ygien ft, file	S	11			Cashi					Store
Physician Medical Examiner  Physician Medical Examiner  To go you have been a consequence of:  Sequentially list conditions, and the sequence of:  Sequentially list condition	be fill H doth	B								Θ)	
Physician / Medical Examiner    Part   Standard   Properties   Section   Part   Properties   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Part   Properties   Part   Part   Properties   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Par	Tyle	10			40	h. Adaliina Addana				Cto to Tio Co	and a 1
Physician / Medical Examiner    Part   Standard   Properties   Section   Part   Properties   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Part   Properties   Part   Part   Properties   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Par	Mal d2st than 7 is n traun				19						
Physician / Medical Examiner    Part   Standard   Properties   Section   Part   Properties   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Part   Properties   Part   Part   Properties   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Par	Healt Healt			oand)	20b. Place of	4152 CY1 of Disposition (Nam	silela High ne of				
Physician Medical Examiner  Physician Medical Examiner  To go you have been a consequence of:  Sequentially list conditions, and the sequence of:  Sequentially list condition	ages nt of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemovai from State							
Physician / Medical Examiner    Part   Standard   Properties   Section   Part   Properties   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Properties   Part   Part   Properties   Part   Part   Properties   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Part   Par	it. P.				Salis					iry, Ma	arylano
Physician / Medical Examiner    Physician / Medical Examiner	Degrade and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a		Mary Beth Bra	dshaw-Pruit	fruit	306 W.	Main Street	- Cris	field, M	ID 218	17
Immediate Ceuse (Final disease or condition resulting in death)   Due to (or as a consequence of):			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th one cause on each line.	e death. Do	not enter the mode	e of dying, such as cerdia	c or respiratory a	rrest,	In	terval Between
Sequentially list conditions are consequence of):			Immediate Course (Final				D 3				ilset and Death
Due to (or as e consequence of):    Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparison   Comparis		_	disease or condition	a	MEI	ASTATI	C BKEA	IST CA	HUCER		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of the completion of conditions and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		ē		Du	ue to (or as e	consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of the completion of conditions and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	uted 1 ansit	ᄪ		b	10 to /ou oo o	, , , , , , , , , , , , , , , , , , , ,				1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute to the cause of the contribute t	exection and in and itel-tree	Exa	if any, leading to immediate	Di	10 (0) 05 0	consequence or,					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of the completion of conditions and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	se be	cai	Cause (Diseese or injury that initiated events	C	e to (or as e	consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont	Attificed ing phy	Med	resulting in death) Last		(					į	
24a. Wes an autopsy performed?  24b. Were autopsy for completion of confidence of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property	ath ce ttendi	lan		d							
24a. Wes en autopsy performed?  24b. Were autopsy performed?  1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    25. Was case referred to medical examiner?  1   Yes 2   No    26. Place of Death (Check only one)  27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)  28a. Date of Injury    28b. Time of    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route	the a	ysic	Part II. Other significant conditions of	ontributing to death but r	not resulting	in the underlying ca	ause given in Part I.	23b. Did	tobacco use cor	tribute to th	a cause of de
24a. Wes en autopsy performed?  24b. Were autopsy performed?  1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    1   Yes 2   No    25. Was case referred to medical examiner?  1   Yes 2   No    26. Place of Death (Check only one)  27. Manner of Death  1   Matural investigation  28a. Date of Injury    28b. Time of Injury    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Injury et    28c. Inju	that the ed by detac		C	OPD				1 🗆	Yee 2XNo	3 Probab	oly 4 ☐ Unkr
25. Was case referred to medical examiner?	requires to been sign should be	leted by								availa	ble prior to letion of cause
25. Was case referred to medical examiner?	Has ela	g L						40.			
Manner of Death   To perform the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the perform of the performance of the performance of the performance of the perform of the perform of the perfor			25. Was case referred to medical				26 Place of Do		/	101	es 2 140
27. Manner of Death 1 Natural 5   Pending investigation 6   Could not be determined 5   Specify   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of	Sicial si certi	O B	examiner?	Hospital:	2   FB/0	utnatient 3 DO	Othors			er (Specify)	
1 1 An A (m) 1	Jing Phy After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b.	Time of 28	8c. Injury et Work?				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	LIVISION Atternation of in by the	Sertifica	3 ☐ Suicide 6 ☐ Could not b	286. Place of Injury	- At home, f 'Specify)	arm, street, factory	, office			er or Rural R	oute Number,
1 1 An A (m) 1	e Hospita n 24 hours e Funere		(Check only 2 Medical Exer	niner: On the basis of ex	camination a	e, death occurred and/or investigation,	at the time, date end place in my opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as state and due to th	ed. e cause(s)
A 40 m (A 40) f	To th To th		29b. Signature and title of certifier			29c	. License number				
7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				W+	- cm		D 4300	18	4/2	5 20	106.
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)	11		30. Name and eddress of person who	completed cause of dea	th (Item 23a)	(Type, Print)					
Vijay Karumbunathan, M.D 201 Hall Highway - Crisfield, Maryland21817	4		Vijay Karumbuna	than, M.D.	- 201	Hall Hig	hway - Crist	field, M	aryland2	1817	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar APR 2 8 7006				32. Registrar's	s Signature	15 Rosel	22				

06-02750 Perry Payne

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death Month Day April 23, 2006 **Medical Examiner** 1034 hrs Perry C. Payne Sr. Perry Payne 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore N/A3424 Park Heights Avenue 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Funeral Feb 19,1960 Foreign Country D Months Hours 46 Director 214-72-8128 1 XM 2 F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits MD N/A Baltimore 1 X Yes 2 No 28a-f show with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3424 Park Heights Ave 21215 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces' White, etc. Yes 2X No Specify Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: hours after ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
pernit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "nati during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry 11th Laborer 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Joseph Howard Payne Virgin Mary Scott 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3424 Park Heights Ave Baltimore MD 21215 Virgin Mary Payne /Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation, 3 5/1/06 Randallstown MD King Mem. Park Cem 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral per ice Licensee Chatman-Harris Funeral Home Jamos F240 Rejected To Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reserve to Reser Physician Between Onset and /Medical Death Cocaine intoxication Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death attending physician and or use as the burial - tran Physician/Medical #item#23a,PII,27,28a-f,perME,g855,5/30/06 TT XUNPENDED X AMENDED of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Linknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Cardiomegaly 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been simporal director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 death? 2 No No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other Nursing Home 5 Inpatient 2 DOA ER/Outpatient 3 Residence 6 V Other: Scene ္ 1 V Yes 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: within 24 hours after the To the Funeral Director: A ___ Natural Division 5 Pending 1 Yes 2 X No Fnd 4/23/2006 unk unk 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City D-1 or Jown, State) 3424 Park Heights Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be Baltimore, MD determined (Specify) Found at residence 4 | Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. April 24, 2006 hus 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day, Year) . Registrar's Signature State

Registrar

28

APR

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 26 QI Apri1 2006 09:10a ian /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth Month, Day Year Nay 18, 192 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) 5. Social Security Number 6. Sex **Funeral** Min. 1□M 2XF Months Days Hours 212-22-181 Usual Residence of Decedent Mar Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Maryland Director mor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir then "natural, or itsms 23a or the Medical Examiner must be or 2 2  $\alpha$ on 6 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates: Blac Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Care permit. Pages 1 and 2 should be filed wil Depertment of Health and Mental Hygient important: If item 27 is marked other the say injury or other traumatic event, the QRE.  $\boldsymbol{\alpha}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P Zabe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Sov.) timore, Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 Woodlawn Cemetery 4 Donation 5 MOther (Specify) Entombment 22. Name and Address of Mcility 21. Signature of Funeral Service Licensee Joseph L. Ryss Funeral Home, P.A. 2222 W. North Ave. Balto. Md. 21216 Home, P.A. 23a. Part / Enter the disease, or complications that eached the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction **Physician** Acute Myocardial Due to (or as a consequence of): unknown /Medical Examiner unknown Due to (or as a conseque ce o ): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 Ø No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ly pormuoid im autopsy performed3 this certificate Malnutation 2 \( \text{No.} 1 Tes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To / *...
/s after dee...
*rai Director: After ...
*rv the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be To the Hospital or Atte within 24 hours after des To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plane, and due to the nause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Gertflar Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier geenawalt MD 00060248 April 26, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore, May land 2120+ J.C. Greenanall, MD Office. 6701 North Charly Street Hoppitalist R 2°8 2006 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Vear **Physician** Susanne Claire Peery 2006 4:30 A April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Funeral 1 □ M 2 👿 F 219-80-2111 45 13. 1960 Washington, Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h Counts 10a State or 28a-f show ir than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🛣 No Maryland Howard Columbia Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9377 Reader Lane 21045 U.S.A. 4 23a c Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Hair Stylist Hair Cuttery other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ss 1 and 2 should be fi of Health and Mental H item 27 Is marked otl Margaret O'Shea Andre Lavanceau 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9377 Reader Lane Columbia, Maryland 21045 Steven Peery (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Depertment of I Important: If it eny injury or o 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Louis Cemetery 4-27-2006 Clarksville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Homes, 1
5555 Twin Knolls Road 21. Signature of Funeral Service License Inc Columbia, Maryland 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years Canuv LUNG **Physician** disease or condition resulting in death) /Medical Due to (or as/a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included and or injury) Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 W No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification; To Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 kg No 1 ☐ Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Specify Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 V No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident hours after deat 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours Medical 29a. Certifier Certifying Physician: To the hest of my knowledge, death occurred at the time, date and lace, and due to the cause s) and manner as stated. 1 Priliping Physician: To the best of my knowled at death occurred at the time, date and make, and due to the cause(s) and make.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RTANUL 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAR ON CHARLES WD 4601 N. CHARLES ST BRATINGS MD ZIROL AARON Charles MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#9, perFH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (Firm, Middle, 3. Time of Death **Physician** Month Year 2006 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Boltimore Simai Hospital 0 bostimore 6. Sex 1 ☐ M 7. Age (In yrs. last birthday) 77 Yrs. If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign T Country) **Funeral** Days Months Hours NJ 212-22-0125 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Executive must be notified at 1 Ses 2 No Funeral Director Dorothy saltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces?

1 Yes Wilho If Yes, Give Year or Dates: or itema Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give king of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Conge (1-4or 5+) Elementary/Secondary (0-12) OLV rs ment of Health and Mental Hy, int: if Item 27 is marked other y or other traumants trsumatic event. Z. Father's Name (First, Middle, Last) ₩iddle, Maiden Surname Mother's Name (First Be . Informant's Naria Relationship (Type. ral Route Number, City or Town, State, Zip Code) 19b. Mailing Add ss (Street and Number 2/2/5 20a. Method of Disposition permit. Pages 1 Department of H 1 ABurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State -200b important: i any injury o once. Noodla 21. Signature of Fun ral Service Ligensee ls town, TAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician /Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 12 No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) : After this ce funeral dire Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature, and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 26 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Registrar's Signature 31. Date filed (Month Ray 2 8 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician Year Roberta E. Rupp 4:2019 25 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Stella Maris Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV . 27, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign MATY)1and **Funeral** 1 ☐ M 2 🛣 F 320-22-9267 84 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 23a or 28a-f ahow the Medical Examiner must be notified at Baltimore Essex MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 460 Stemmers Run Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or itema 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White þ 3 Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Chesapeake Ford Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be fil tment of Health and Mental H tent: If Item 27 Is marked off Florence E. Fickensher George W. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2808 Preston Lane Abindon MD 21009 Jay Rupp /son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ò 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rossville MD 4/29/06 Gardens of Faith 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex onn 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ement **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of):  $\mathcal{U} \ \mathcal{P} \ \mathcal{K} \ \mathcal{D} \ \mathcal{E} \ \mathcal{L} \ \mathcal{U}$  Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No : After this certifical funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: al or Attanture are after death. 1 Naturaf 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 10 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2300 Dulaney Valley Rd. Timonium, MD 21093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood, MD 19419 APR 2 32. Registrar's Signature 31. Date filed (Month, State Goods 2006 Registrar

06

6-02793		Please Ty								
ae Rideout		State of Maryland				nd Menta	al Hygiene	13	006	220
		1- For State Registrar	Certin	ficate o	f Death		R	leg. No	000 1	1000
Physicia		Decedent's Name (First, Middle,Last)					Date of Dea     Month		/ 025	e of Death
Medical Exami	ner	Fay Ann Stogdon Rideout					April 25, 2	2006	033	30 hrs
		4a. Facility Name (if not institution, give street and number)			4b. City, Town,	or Location of	Death	4c Count	ty of Death	
		Johns Hopkins Bayview Hospital			Baltimore					_
Funeral			(In yrs. last	birthday)	If Under 1 Ye	ear If Under 2 ays Hours	24Hrs. 8. Date of Bi Min.	rth (MM/DD/YY	YY) 9 Birthplace ( Foreign	(State or
Director		216-50-2720 1 M 2X F	58	Yrs		ays Hours	11-26-1	1947	Country)	MD
*		Usual Residence of Decedent								
₩ 2B		10a. State 10b. County	10c. City, To							side City Limits
daryland 28a-f show any d at once.	Į,	MD NA		Balti					1 X	Yes 2 No
Mary r 28a ed at	Director	10e. Street and Number			10f. Zip Code		1	-	What Country?	
ith the A		4021 Cedardale Road			21215			USA		
th with ems 2	Funeral	11 Marital Status 1 Never Married 2 Married Armed Forces?	Ever in U.S.				? (Specify Yes or No uerto Rican, etc.)		ice - American India nite, etc.	an, Black,
r dea or it	Fur	1 Yes 2	X No				,			
s afte rral", niner	ò	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	-lated\	1	Yes 2x N		4-5 1-4		Black	
hour natu Exar	ted	15. Decedent's Education (Specify only highest grade com  Elementary/Secondary (0-12)  College (1-4 or 5			nt's Usual Occup nost of working li			16b. Kind of	Business/Industry	
336 thin 72 than than edical	ompleted	10	,,		Droccor			Clea		
5-00 led with Hygiene other the Me	E O	17. Father's Name (First, Middle, Last)								
11215-0036 Id be filed within 72 hours after Aental Hygiene. narked other than "natural", event, the Medical Examiner.	Be C	Edward Stogdon	ille Holmes	margori ourran	10)					
21215-0036 Juld be filed within 7 Mental Hygiene marked other than	<u>0</u>	19a. Informant's Name/Relationship (Type, Print )		19b. Mailin	g Address (Stre		er or Rural Route Nur	mber, City or To	own, State, Zip Cor	de)
MD nd 2 sho alth and m 27 is		Lucille Stogdon/Mother	4021 Cedardale Road Balti					21215		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition			sition (Name of c	emetery,	Date	20c. Location	n - City or Town, S	tate
DOC ages ort of other		1 X Burial 2 Cremation 3 Removal from Sta	.~	matory or ot		h	-29-06	Lansdov	me MD	
Baltimore, permit. Pages I at Department of Her Important: If ite injury or other tr	11	21. Signature of Funeral Service Licensee 22. Name and Address of Facility								
De De De De De De De De De De De De De D	6 3	Smela Jones					38 N. Gilmo	r Street	Balto, MD	21217
Physician		23a. Part I. Enter the disease, or complications that caused	he death. Do						neart Appro	ximate Interval
/Medical	5 53	failure. List only one cause on each line.  Immediate Cause (Final disease a Methadone	intoxic	ation a	and cirrho	neie of 1	ivor		Betwe	een Onset and Death
₹xaminer		or condition resulting in death)  Due to (or as a conse		delon c	aki Chilik		1701			
-		Sequentially list conditions, b								
	ine	if any, leading to immediate Due to (or as a conse	quence of):							
-	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a conse	quence of):							
executed ian and ial - transit		d						•••		
oe exe ician a	dical	Xunpended IX amended it	em#1,23	a,PII,2	27,28a-f,p	erME,g85	5,5/18/06 T	Γ		
Box 68760, e death certificate be the attending physicied for use as the buri	Physician/Med	IF FEMALE: 23c. If yes, outcom	e of pregnar	псу			-	23d. Date	of delivery	
68 certif	ä	past 12 months?	ime of death	=	tal death 3	Ectopic p	regnancy	Month	Day	Year
Sox leath e atte for u	ysic	1 Yes 2 No 9 V Unknown 9 Unknown		5 Ot	her (Specify)					
that the detached		Part II. Other significant conditions contributing to death	but not resu	ilting in the u	underlying cause	given in Part	I. 23e. Did to	obacco use cor	ntribute to the caus	e of death?
, P.O.	d b	Diabetes mellitus; obesity					1 Yes	s 2 No	3 Probably 4	<b>✓</b> Unknown
cords, law requir has been s	ompleted						24a. Was	an   24b	. Were autopsy fin	dings available
COI law has l	ם		<del></del>				autop perfo	rmed?	prior to completio death?	n of cause of
Recc: The lav	ပ	OF Was and of such a state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t			20.5		1 🗸 Yes	2 No	1 Yes	2 No
Vital Rec hysician: The this certificate I director, page	å	25. Was case referred to medical examiner?	+ 2 2 5	R/Outpatient		Other		Desiring a		
n of V ding Phys	2	1 Ves 2 No Inpatier 1 Inpatier 27. Manner of Death 28a. Date of Injur		3b. Time of I		jury at Work?	lursing Home 5 28d. Describe	Residence 6		
on of ading Pl th :: After e funera	ertification:	1 Natural 5 Rending	ar)			Yes 2 X N	_	now injury occu	iii ed	
isior Attenc r death ector: by the	cat	2 Accident Investigation TNG 4/25/2		nd 2:30	, All		quir.	Stroot and Num	phor or Burol Bout	Number City
Divi	늴	determined (Specific) for	und at :			building, etc.	Baltimore	State) 4808	ber or Rural Route Truesdale	Ave
	O	29a. Certifier				date and place				
To the Howithin 24 h To the Fur	ledical	one) 2 Medical Examiner: On the basis of exam								s)
To To	Mec	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date sig	ned (Month, Day,	Year)
	001	hig his, mos			0.0	.M.E.		April 26, 2		,
		30. Name and address of person who completed cause of de	ath (Item 22	la)				L		
6	. 3	Ling Li, MD Assistant Medical Examiner		•	et, Baltimore	, MD 21201				
V	ate	31. Date filed (Month) Pey 2ea 2006 32 gistrar		-	<u> </u>					·
Regist		APR & O LUUD	U 15	1000	use					

Amend Item: 20b per F.H G-854 4/28/06 reb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	iryland / I		artment of F tificate of I			Re	g. No.		13392
H	Physicia /Medic		1. Decedent's Name (First, Middle, Las Sylvia Robinso							Date of Death Month	Day	Year 2 006	3. Time of Death
)	Examin		4a. Facility Name (If not institution, give Good Samaritan		1		4b. City, Town, or Baltimo		ath		4c. Count	y of Death A	
	Funeral Director		5. Social Security Number 215-30-0418 6. S	ex 7. Age □M 2& F 7	(In yrs. last bii 2	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. J	Date of Birth (Month Day, all	^y ¶ ^a 934	9. Birthp Court	place (State or Foreign MD
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, Tow							1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Marylan ms 23a or 28a-f show must be notified at	i Director	10e. Street and Number 7070 Cradleroc	k Way Ap	t# 210	)	10f. Zip Code 2104	15		10	g. Citizen of	What Cour USA	ntry?
036	n 72 hours after death with the Maryland "neturel; or items 23a or 28a-t show edical Examiner must be mylified at	by Funeral	11. Marital Status  1∑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Types 2 N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba  □ Yes 2  No	ispanic Origin? an, Mexican, Pu Specify:	(Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Specification (Speci	y Yes or No- can, etc.)		ce - Americ ack, White,	
21215-0036	within 72 ho liene. r then "netur lie Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2 t h			(Give life.	dent's Usual Occup. kind of work done of DO NOT use retired Cretary	ation during most of v	working	1	6b. Kind of E	Business/Ind	
land	uld be filed fental Hyg rked other itc event,	To Be C	17. Father's Name (First, Middle, Last) John Robinson							First, Middle, M Aldern		me)	
Mary	s 1 and 2 should f Heelth and Men flem 27 is marke other traumatic		19a. Informant's Name/Relationship (1 Paulette Moore				ng Address (Street a						
baltimore,	permit. Pages 1 a Depertment of Hee Important: if Item eny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place o cemete Green	of Dispo ory, cren 1MO1	sition (Name of natory or other plac unt Cres	4/24/0 natory	6 Date	2 <del>2/0</del> 5	oc. Location Balt	-	
Dall	Depenti Depenti Import eny inj once.		21. Signature of Funeral Service Licen	reis		5	240 Reis	sterst	own	Rd Ba	11tim		eral Home AD 21215
, 1	Physician		23a. Part1. Enter the disease, or composition of the shock, or hear failure. List only immediate Cause (Final disease or condition	one cause on each lin	the death. Do e.	not ent	er the mode of dyin	g, such as card	liac or re	espiratory arre	st,		Approximate Interval Between Driset and Death
	/Medical Examiner	e.	resulting in death)  Sequentially list conditions,	6 Hyper	consequence	2~~	in due	to ly	mp	hme			
68/60,	ticate be executed physician and is the burial-transit	cai Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Arien	consequence								
×	attending tor use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 12 □ Pregnant at 19 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)					ate of delive	ry Day Year
ecords, P	w requires that the death been signed by the atter should be detached for u	۵	Part II. Other significant conditions of	3	t not resulting i	n the ur	nderlying cause give	en in Part I.					e cause of death?
nec	The law ate hes b page 2 s	Completed	Hyperterioro Degeneralis	n e sou	t Die	- Rev	nu		-	24a. Was an autopsy perform		prior to cor death?	osy findings available inpletion of cause of
	siciar s certif lirecto	o Be	25. Was case refer d to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	* 2 T EP/O	utnation	t 3 DOA Othe	or /		5 ☐ Resider	-	h (0 t	
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifical completely filled in by the funeral director,	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	y. 28b.	Time of	28c. Injun Worl			Describe hov			0
	al or Atter s atter dea il Director d in by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	arm, str	eet, factory, office		28f.	Location (Stre City or Town,	eet and Num State)	ber or Rura	l Route Number,
	ne Hospitt n 24 hours ne Funera pletely fille	edical C	29a. Certifier (Check only one)	ysician: To the best of iner: On the basis of and manner state	examination an	e, death	occurred at the time restigation, in my op	ne, date and pla pinion, death oc	courred	due to the cau at the time, dat	use(s) and m	anner as st and due to	ated. the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier	g hai			29c. License				d. Date sign	-	
	9		1 deur	M.	り			11464			4 PRII	_ 19.	2006
1	3		30. Name and address of person who of SHOAIB A. H		ath (Item 23a)	(Type, /\/	Print)	NCL	G '	L 25	RAI	Tima	RE MD 2120
W	Sta Registra	_	31. Date filed (Month, Day, Year) APR 2 8 20	A S++ M 1 32 Registra	r's Signature	A Take	XED	J T	<u> </u>	10 34	1)110	_ 11/11/	NE III D KIZU

		1- For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 13393
	/sician	1. Decedent's Name (First, Middle, Last)  RAMONA ROBERTS  2. Date of Death  Month  Day  Year  7: 20 (M
	ledical aminer	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A
Fund Direct		5. Social Security Number 219-30-0506 6. Sex 1 Months 74 Yrs. 74 Yrs. 74 Yrs. 75 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Mon
iryland	ie .	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
the Marylar r 28a-f show	Director	MD BALTIMORE PIKESVILLE  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
sath with	ral D	4116 BALMORAL CIRCLE 21208 USA
5-0036 172 hours after death w	Examiner must	3 ☐ Widowed 4 1 Divorced   If Yes, Give 1 ☐ Yes 2 No Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   S
1 21215-0036 Is a vithin 72 hours after death with the Maryland hygiene. her than "natural", or ftems 23a or 28a-f show	reumatic event, the Medical Examinst must be notified at To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 1 2 TH  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  VERIZON
HS Rum on ore, Maryland 212: st 1 and 2 should be filed within and Mental Hygiene.	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Maryland Maryland to should be fill the and Mental Hy	raumati	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Feat tan	othe	DEBORAH M. SYDNOR/Guardian 4116 BALMORAL CIRCLE, PIKESVILLE MD 21208  20a. Method of Disposition  1
Baltimor	any inju	21. Signature of general Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD
Physic	ian	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Immediate Cause (Final disease of condition  a. Multi-Organ Tauluse  Approximate Interval Between Onset and Death
/Medi Exami		Due to (or as a consequence of):
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fundard Director Attent this certificate has been signed by the attending physician and	the buriat-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Drewner in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control
P.O. Box 61 hat the death certific d by the attending p	etached for use as the but but but but but but but but but but	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
ords, P equires that	cuid be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Yunknown
Division of Vital Records, for Attending Physician: The law requires ta after death.  Director: After this certificate has been signer browners.	Completed	dysphagia  Quintestin bleding, anemin, pressure Ulas  24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No
f Vita ysician	To Be	25. Was clase referred to medical examiner?  1   Yes   2   No   1   No pital: 1   No pital: 2   ER/Outpatient   3   DOA   Cther. 4   Nursing Home   5   Residence   6   Other (Specify)
On O ding Ph After th	runeral tlon:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Vork? 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred
Division and or Attents a ster deat	ed in by the funeral	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 7 Home, farm, street, factory, office 6 Homicide 7 Homicide 7 Home, farm, street, factory, office 7 Homicide 7 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homicide 9 Homi
the Hospitt in 24 hours	ledical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		29b. Signature and title of certifier  Program:  29c. License number  29d. Date signed (Month, Day, Year)  1 0060170  29d. Date signed (Month, Day, Year)  4 25 2006
	)	30. Name and address of person who completed cause of death (Item 23a) ype, Print)  1. (
Rec	State gistrar	31. Date filed (Month Pay, Year) 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a, perFH 2854, 4/28/00 TT Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician APRTL** 25^{Day} 2006 MARILYN RADERMAN 4:04 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2□F 215-44-1736 60 Director 11/06/1945 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits t of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Modical Examitier must be notified at MD BALTIMORE WHITE HALL 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 811 WISEBURG ROAD 21161 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE ģ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 OFFICE MANAGER DENTAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Mental **KERN** CHARLES MIRIAM GRESSER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:: Department of Health at Important: If Item 27 is any injury or other trau 811 WISEBURG ROAD - WHITE HALL, MD 21161 MICHAEL RADERMAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 № Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HAR SINAI CONG. 04/27/2006 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CATS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? eral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) tho completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto MY 21208 6701 C Sparke 32 Registrar's Signature 31. Date filed (Month, Day, State 2006

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>		of Health a of Death	and Menta	l Hygier	401	)6     3395
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La     Ada May Sneeringe      4a. Facility Name (If not institution, give Saint Joseph	e street and number)	Cantas	4b. City, To	wn, or Location of	Mor	AFRIL	25 . 2 4c. County of	
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday) 95 Yrs.	If Under 1 \ Months D			of Birth orth, Day, Yea 29,19	ar) 9	altimore Birthplace (State or Foreign Country) aryland
	the Maryland 28a-f show	Director	10a. State 10b. County  Maryland Baltimo:  10e. Street and Number		10c. City, Town or Lo	10f. Zip Co	odo		100.0	Citizen of Who	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
98	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-f show he Mudical Exeminer cust te inclified at	Funeral	2346 Martin Drive  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2020 No If Yes, Give		212	221 t of Hispanic Orig Cuban, Mexican,	gin? (Specify Yes , Puerto Rican, e		J.S.A.	American Indian, White, etc.
21215-0036	within 72 hours ene. then "neturel", ne Medicel Ex	Completed by	3 ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣ ♣	Year or Dates:	16a. Dece (Give	dent's Usual C kind of work of DO NOT use i	occupation	of working		Kind of Busir	White mess/Industry  ity Public Sch
Maryland 2	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last, John Walter Smith				Annie	117.0	Middle, Maid	en Surname)	
	permit. Pages 1 and 2 should in Department of Health and Men Important: if Item 27 is marke any injury or other traumatic.		19a. Informant's Name/Relationship ( Robert Sneeringer  20a. Method of Disposition 1 短短vial 2 □ Cremation 3 □	(Son)	2346 20b. Place of Dispo cemetery, cree	Martir	r place)	Baltimo	ore, Ma	aryland Location - Cit	21221 ty or Town, State
Baltimore,	permit. Pag Department Important: any Injury once.		4 Donation 5 Other (Specif		Parkwood		ery Aradress of Facility	pril 28, Bruzdz I Fastor	2006 I zinski n Aver	Baltimo Funera Nue, Es	ore, Maryland al Home, 1221
	Physician /Medical Examiner	er.	23a. Part or the disease, or com so k, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. ACUTE I  Due to (or as a	rivocardi consequence of):				atory arrest,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physicien end of for use as the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
P.O. Box 6	that the death certifical ned by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	Ectopic pregr Other (speci				23d. Date of Month	,
Records, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions of RENAL FAILURE	ontributing to death but	not resulting in the u	nderlying caus	e given in Part I.	236	Did tobacci	41	ite to the cause of death?  Probably 4 Unknown
Vital Rec	Physicien: The law requires that the this certificate has been signed by the tail director, page 2 should be detached.	e Completed	25. Was case referred to medical				26 Place		. Was an autopsy performed Yes 2 2 1	prio	re autopsy findings available ir to completion of cause of th? Yes 2 No
of Vi	Physici this cer al direc	To B	examiner? 1  Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpatier		Other: 4 Nur	sing Home 5	Residence		(Specify)
Division	ttending death. stor: After the fune	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	(Month, Day	(ear) Injury	М	Injury at Work? 1 Yes 2 N	No 28f. Loca			or Rural Route Number,
	To the Hospital or A within 24 hours efter To the Funerel Directompletely (illed in by	Medical C	one)	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	n occurred at t vestigation, in	he time, date and my opinion, death	d place, and due th occurred at the	time, date a	ind place, and	I due to the cause(s)
<b>)</b>	To With	2	29b. Signature and title of certifier  30. Name and address of person who	Helen,	M - A_	D	17695		29g. C	Pate signed (A	26, 2006
1	Sta		ARDALLAH J. HE 31. Date filed (Month, Day, Year)	32 registrar	7601 OSL		RIVE TO	WSON M	ARYLA	ND 21	204

Physician	<ol> <li>Decedent's Name (First, Middle)</li> </ol>	(ast)			lealth and N Death	2. Date of De			3. Time of Death
						Month	Day	Year	
/Medical	A e ce S  4a. Facility Name (If not institution,	rive street and number)	4b. C	ity. Town, or	Location of Death	April	4c. County	of Death	4150
Examiner				,	RANDAL		10. 00 1		TIMORE
uneral	5. Social Security Number	6. Sex 7. Age (In yrs.	last birthday) If Un	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8 Date of Bir	th v. Year)		
	215-16-0140	10 M 20 F 56	Yrs.	Days	TIOUIS WIII.	DEC.31	,1919		place (State or Foreig intry) POLAND
	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Location						10d. Inside City Limit
ō									1 Yes 2 N
Director	10e. Street and Number	mane Re	10t.	Zip Code			10g. Citizen of	What Cou	intry?
	101 wood	Loda a Nue		2_/	208				USA
Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was De		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No	- 14. Rac	e - Ameri ck, White	can Indian,
٧Fu	1 Never Married 2 Marrie	ad 1 ⊡Yes 2 🐧 No If Yes, Give		s 2 <b>∏</b> No	Specify:		Specif		WHITE
id by		Year or Dates:			-4				
Completed	15. Decedent (Specify only highest	t grade completed)	16a. Decedent's U (Give kind of life. DO NO	work done of work retired	ation during most of work f)	ring	16b. Kind of B	usiness/ir	ndustry
шо	Elementary/Secondary (0-12)	College (1-4or 5+)	SECRETAI		,		SOUTHE	RN LA	CQUER
Be C	17. Father's Name (First, Middle, L	.ast)			18. Mother's Nam	e (First, Middle,	Maiden Surnar	ne)	
To B	BERNARD			DIC	DICKSTEIN				
ľ	19a. Informant's Name/Relationsh		_		and Number or Rur				
	MICHAEL ROSEN	BLIT / BROTHER			MA DRIVE	- ELDERS	SBURG, 1	4D 21	.784
	20a. Method of Disposition  1 🛱 Burial 2 🗆 Cremation	3 DRemoval from State	Place of Disposition (/ cemetery, crematory of	or other plac	e)	Date	20c. Location		
	'4 □ Donation 5 □ Other (Sp	DR	UID RIDGE						LE, MD
	21. Signature of Furieral Service L	Licensee			ss of Facility SO				
	Jan )	complications that caused the deat only one cause on each line.		-	ERSTOWN			LE,	MD 21208 Approximate
dical Examiner	Immediate use (Final disease or condition resulting (death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence o	uence of): uence of):	evla	ACE	- nant:			Onset and Death
Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐Ectopic	c pregnancy (specify)				te of deliventh	ery Day Year
þ	Part II. Other significant condition	ns contributing to death but not res	ulting in the underlyin	ig cause give	en in Part I.				he cause of death? bably 4 🞢 Unknown
Completed						24a. Was autop perfo 1 \( \text{Yes} \)	rmed?	Were autoprior to codeath?	opsy findings available impletion of cause of
Be	25. Was case referred to medical examiner?	xx Inpatient			26. Place of Deat	h (Check only o	ne)		
은	1 Yes 2 No		ER/Outpatient 3	T 100	4   Nursing Ho				(y) # e
Certification:	27. Manner of Death  1 Natural 5 Pending		28b. Time of Injury M	28c. Injury Work	rat ⟨? Yes 2 □ No	28d. Describe h	low injury occur	rea	
lical	2 Accident investig	ot be				28f. Location (S	Street and Numb	er or Run	al Route Number,
ertii	4 Homicide determin	building, etc. (Specif	y)	tory, office		City or Tou		01 01 11011	ar riodic rioni,
edical C	29a. Certifier Certifying (Check only 2 Medical E	p Physician: To the best of my kno examiner: On the basis of examina and manner stated.	wledge, death occurr tion and/or investigati	red at the timition, in my op	ne, date and place, pinion, death occur	and due to the or	cause(s) and madate and place,	inner as s and due t	stated. the cause(s)
Me	29b. Signature and title of certifier		:	29c. License	number		29d. Date signe	d (Month,	Day, Year)
	be			20	2000=		in .	g	2 000
	30. Name and address of person v	who completed cause of death (Item	n 23a) (Type, Print)	UL	2085		100-1	24	2006
	MULL J. C.		_	0 0	Cour	Raen		2	1153
State gistrar	31. Date filed (Month, Day, Year)  APR 2 8 2006	32. Registrar's Signa	iture						

06-02481 Kimberly Skvers Amend Items: 10e & 10f per F.H G-854 4/48/06 reb
Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hy

mberly Skyers		I- For State	of Maryland / Depa <i>Cer</i>	rtment of Hea tificate of Dea			200	6 1339			
Physicia	_	Registrar  1. Decedent's Name (First, Middle,Last				2. Date of Death Month		3. Time of Death			
ledical Exami	ner	KIMDERLY (	, SKYERS	<u> </u>	•	April 11, 20		1714 hrs			
)		4a. Facility Name (if not institution, given 2638 St. Benedict Street	e street and number)		, Town, or Location of Dea imore	ath	4c. County of Death	1			
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	ast birthday) If Ui	nder 1 Year   If Under 24H	Irs. 8. Date of Birti	h(MM/DD/YYYY) 9. Bir				
Director		610-16-6703 1	M 2 F 33	Yrs. Mor	iths Days Hours M	in. 09-10	-1923 Foreig	untry CALLE			
апу		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location				10d. Inside City Limits			
*		A/A	100.00	1	0 E			1 Ves 2 No			
Maryland 28a-f show : d at one	Director	10e. Street and Number Unk		AH 1 ma	Cip Code Ukn.	10	g. Citizen of What Cou	ntry?			
the Man 2		2638 St Be	nedict 5	i l	223-2043	_	IN. 8. A				
ith with	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?		dent of Hispanic Origin? ( cify Cuban, Mexican, Pue		14./Race - Amer White, etc.	ican Indian, Black,			
ter dea ", or it er mus			1 Yes 2 No	1 Yes	2 No specify:		Specify: B/	Ack			
ours af atural xamin	d by	15. Decedent's Education (Specify or	or Dates:	16a. Decedent's Usu	al Occupation (Give kind o		16b. Kind of Business/	Industry			
16 n 72 h nan "n ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	0 .	vorking life. DO NOT use r	eureu)	Differe	2			
5-0036 led within 7 Hygiene. other than	,om	17. Father's Name (First, Middle, Last)	1+	CATERIA	/ 18.Mother's Na	me (First, Middle, M	CHTERING  Iaiden Surname)	Companie			
21215 uld be file Mental Hy marked o	å	RONALD VICT	OR SKYL	FRS	CARO	IVN C	DODER	, ,			
	ဥ	19a. Informant's Name/Relationship (T	ype, Print )	19b. Mailing Addre	ss (Street and Number o						
무를통통		CAROLYN C: 51 20a. Method of Disposition		Place of Disposition (N		Date	20c. Location Sity or	ES CA 90043 Town, State			
altimore, mit. Pages I a partment of He portant: If ite		1 Burial 2 Cremation 3		crematory or other place	L C	bohout	Rolls 1	m			
Baltimo permit. Pag Department Important: injury or o		4 Donation 5 Other Specify: 21 Segreture of Funeral Service Licen	see \	een meun 22. Name a	nd Address of Facility	nES.TR.	Fun. 5	VEPA			
<b>™</b> % % ₹ ∄		Plova adas	no forces	1814	N. BRO	ANWAU		10. 2/2/3			
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	ch line.		e of dying, such as cardia	c or respiratory are	st, shock, or heart	Approximate Interval Between Onset and Death			
xaminer		1141 141 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sharp and Blunt Force Due to (or as a consequence or					Death			
		Sequentially list conditions, b.									
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.	Due to (or as a consequence o	r):							
ecuted and transit	Examiner	events resulting in death) Last	Due to (or as a consequence of	f):							
execution and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and training and and training and and and and and and and an	Medical	UNPENDED d.	AMENDED								
760, cate be ex physician the burial	Med	IF FEMALE:	23c. If yes, outcome of preg	nancy			23d. Date of deliver	у			
Box 687 death certific he attending p	sician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of de	2 Fetal dea		nancy	Month	Day Year			
Box 6876 he death certifica the attending phed for use as the	Physi	1 Yes 2 No 9 V Unknown	9 Unknown								
ires that the signed by I be detach	by P	Part II. Other significant conditions	contributing to death but not re	esulting in the underly	ng cause given in Part I.		bacco use contribute to				
rds, requires						- 24a. Was a		utopsy findings available			
cor e law n e has b ge 2 sho	Completed					_ autops	med? death?	completion of cause of			
tal Rection: The I		25. Was case referred to medical	·		26.Place of Death (Chec	1 Yes 2	2 No 1 Y	es 2 No			
Vita hysicia this cel	To Be	examiner?  1 ✓ Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nur	sing Home 5	Residence 6 🗸 Othe	r: Scene			
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should!		27. Manner of Death  1 Natural 5 Panding	28a. Date of Injury FOUND:	28b. Time of Injury FOUND:	28c. Injury at Work?	28d. Describe h Subject assa	ow injury occurred				
Sion Attener f death ector: by the	cati	2 Accident Pending Investigation	4 44 .0000	1710 hrs	1 Yes 2 No	28f Location (S	treet and Number or Pu	ural Route Number, City			
Div pital or ours afte teral Dir filled in	Certification:	Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify) Vacant Building Cor Town, State)  (Specify) Vacant Building 2638 St. Benedict Street, Baltimore,									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physici	an: To the best of my knowled			nd due to the cause	e(s) and manner as star	ted.			
To th withir To th compl	Medical	one) 2 Medical Examiner  29b. Signature and title of certifier	On the basis of examination a and manner stated.		my opinion, death occurre	d at the time, date a					
		Cal L old	NOS 0 000		O.C.M.E.		29d. Date signed (Mo	inii, Day, Fear)			
6		30. Name and address of person who	completed cause of death (Item	23a)							
2					, Baltimore, MD 212	201					
St Regis	ate	31. Date filed (Month, Day, Year)  APR 2 8 2006	32. Registrar's Signatu	ire Assistant							
			100	describ.							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 04:11 MM Sheel 23 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) 89 Yrs. Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. March 299,1917 1200 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign Months Days 1 □ M 2 F Maryland 215-03-8564 Director Usual Residence of Decedent 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits **ehow** Item 27 is marked other then "natural", or Items 23a or 28a-f ebor other traumatic event, the Modical Examinar must be notified at Director 1 Ves 2 □ No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3138 Strickland Street 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be Mary Hudson John McNemara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 Hooper Avenue; Arbutus, Maryland 21229 John Sheeler Son tem 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite eny Injury or ot once. 1 ⊠Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 4/27/06 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Fundral Service Lices Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-translt Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۵ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown leted certificata has been si rector, page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? Compl 2 No 1 Yes 2 No 1 TYes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ➤ ER/Outpatient 3 ☐ DOA 2 1 Tes 2 No SE SE funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural 5 Pending nours efter death. Ineral Director: Aft filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide thin 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Func (Check only one) ŧ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 mkerm April 24 2006 30. Name and address of person who completed cause of death (Item 23a); (Type, Print) S-BASKALW 3455 WILKEM BACTIMORE -MD 21229 455 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 24, 2006 Anna Agnes Stonesifer April 5:30 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paradise Assisted Living Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 20, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 【XF 213-09-6123 94 Yrs 1911 Maryland Director Usual Residence of Decedent death with the Maryland 10d. fnside City Limits 10c. City. Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itema 23a or 28a-f ehow with Injury or other freumatic event, the Medical Examinations be notified at once. 10a. State 10b. County 1 ☐ Yes 2x No Directo Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 6348 Frederick Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Bfack, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Coflege (1-4or 5+) Sales Person Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James H. Gamber Sally Ann Lilly ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Rest Avenue; Catonsville, Maryland 21228 Patricia M. Engel Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Good Shepherd Cem. 4/29/06 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee en 1630 Edmondson Avenue; Catonsville, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYDEARDIAL INFARETION /Medical Due to (or as a consequence of): Examiner CARDIOVASESLAR DISENSE MANT ATHEROSELEKOTTE Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 4 CARS Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificete Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 15513560 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ LIVING this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth. neral Director: / 2 Accident 6 ☐ Coufd not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0025844 APRIL 24, 2006 DED PREDERIEL RD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTNE L. Commerceの人の、MD 3年11 BAUTMORE 32. Registrar's Signature 31. Date fifed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ODIGINIAL

			For State	State of Marylan			Mental Hyg	giene) 06	13400
4		4	Registrer  1. Decedent's Name (First, Middle, Last)		Centilica	ate of Death	2. Date of Dea	_	3. Time of Death
48,	Physici /Medio		Rosina S	pell			April	25,2006	8,00 7
4	Examir	er	4a. Facility Name (If not institution, give s	tribet and number)	4b. C	ty, Town, or Location of De	ath '	4c. County of Deat	h
	Funeral	_	5. Social Security Number 6. Sex	7. Age (In yrs.	Month	der 1 Year   If Under 24 H		Year 7 ASP	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	18	Yrs.		Dec. 1,	1721 NI	arylana
	Aarylan show	ŏ	10a. State 10b. County	10c. Cit	ty, Town or Location	0.50			10d. Inside City Limits 1 XYes 2 □ No
	r 28a-f	<b>Funeral Director</b>	10e. Street and Number	, t	Dain 14	Zip Code	1	10g. Citizen of What Co	
	s 23e o	ralD	425 S. Aug	gusta A	ve.	21229		US	A
9	after de or Item niner n	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2 No</li> </ol>	If Yes, s	pecify Cuban, Mexican, Pu	(Specify Yes of No- erto Rican, etc.)	14. Race - Ame Black, White	
5-0036	filed within 72 hours after death with the Maryland Hygiene. yther then "naturel", or Items 23e or 28a-f show int, the Madical Examinar must be rediffed at	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	16a. Decedent's U	sual Occupation		Specify: B	ack
21215	thin 72 e. en "na Medic	Completed	(Specify only highest grade Elementary/\$econdary (0-12)	College (1-4or 5+)		work done during most of v	vorking	Tob. Kind of Business	moustry
d 21	filed with Hygiene. other ther	Con	17. Father's Name (First, Middle, Last)	0	La.	DOPEF 18. Mother's N	ame (First, Middle,	Maiden Sumame)	14
/land	should be and Mental marked o	To Be	Pete Boo	Ker		Ell.	en F	ord	,
Mary	C1 00 08		19a. Informant's Name/Relationship (Ty)	00. Print) (daughter	19b. Mailing Addr	ess (Street and Number or	Rural Route Number	r, City or Town, State, 2	Tip Code)
	of Health of Health if item 27 or other tr		20a. Method of Disposition		Place of Disposition (fi	Vame of prother (lace)	Date	20c. Location - City or	Town, State
Baltimore,	permit. Pages Department of Important: If it eny injury or o		1 ABurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Kı	ng Men	1. Park 5/1	12006	Balto.	Md.
Bal	permit. Departr Imports eny inju		21. Signatule of Funeral Service License	RUSS	Jose 2222	and Address of Edility  Oh L. KUS	S Fune	ral Home	P, A.
	<b>2</b> 1 645		23a. Part Enter the direase, or complish 3, or heart finure. List only or	e mons that sed the deat e cause on each line.		node of dying, such as card	iac or respiratory arr		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	A cute  Due to (or as a consequence)	wence of):	caldial	2 ma	ection	3100, 410 00411
	Examiner		Sequentially list conditions,	Corona	cef /	tritay	Desea	26	
	uted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of)}}	Q			
ó,	ate be executed thysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
09289	ficate b physic s the b	edicai							
Вох	ith certi	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		: pregnancy		23d. Date of del	ivery Day Year
P.O.	w requires that the death certifics been signed by tha attending pt should be detached for use as t	Physician/Med	1 Yes 2 2 No 9 Unknown	4☐Pregnant at time of d 9☐ Unknown	leath 5 Other	(specify)		MONT	Oay Fear
	es that igned b	by Pł	Part II. Other significant conditions con	_ ( ) .	ulting in the underlyin	g cause given in Part I.		bacco use contribute to	
Records,	v requir been s should	eted	Scer 211	ues sy	raiovia	<u> </u>	1	es 2 No 3 Pr	
	The lay	Completed					- autops perfor	sy prior to death?	topsy findings available completion of cause of 2 No
Vita	ilcian: certific rector,	Be	25. Was case referred to medical examiner?	cspital:	/	Other	eath Check only or	19)	
ō	g Phys er this eral dii	n: To	27. Manner ath	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?		ence 6 □Other ( <i>Spe</i> cow injury occurred	orfy)
Division of Vital	uttendin death. ctor: Aft y the fur	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Injury M	1 ☐ Yes 2 ☐ No			
N N	al or At e efter d i Direct d in by	ertifi	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fac (y)	ory, office	28f. Location (Since City or Town	treet and Number or Ru n, State)	iral Houte Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours eltar death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 ertifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death od	ce, and due to the c curred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 7 To the comple	Med	29b. Signature and title of certifier	and manner states.		29c. License number	C- 2	29d. Date signed (Monti	
	de		* Arece (18	CCUMD		006/9		4/26/2	2006
2	-		ANIL UBE	mpleted cause of death (Iter	n 23a) (Type, Print)	ALLS RI	BAZ	TOMDE	2611
1000	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 20	32. Anglistrar's Signa	ature	2)-			
DHI	MH 17 Rev 1/2	- h	717 12 0 20	UO JURINE	is property				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 2006 **Physician** 10:55AM Raymond W. Souza /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 □ F 016-16-6994 Yrs. May 31,1922 83 Massachusetts Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f ehow item 27 is marked other than "natural", or iteme 23a or 28e-f shov other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Director Howard Columbia Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 6336 Cedar Lane Apt#256 21044 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. I ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 21 No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Refrigeration, al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumbing, Heating Technician 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, fimportant: if Item 27 is marked othe any injury or other traumails event 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Margaret J. Andrews Manuel Souza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8208 Michaels Ridge Ellicott City, Maryland 21043 Ida Reis (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Catonsville, Maryland Metro Crematory 4-26-2006 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility}
Witzke Funeral Homes, Inc.
5555 Twin KNolls Road Columbia, Maryland 21045 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive 1 Rons Physician /Medical Due to (or as a consequence of): Examiner YUND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the at the detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions cophibuting to death but not resulting in the underlying cause given in Part I. Completed by Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2√No this certificete Division of Vital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 ther (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this c funeral dire ၉ 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: Af 2 Accident investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide to the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Jen 23a) (Type, Print) N. Charles St. 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month a 0:18 PM **Physician** Stokes <u>Jose</u>ph 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt Koseda Samare Hospita Franklin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 01 · 23 · Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours 1 XM 2□ F Months Days MD 218.82.485 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County of Health and Mental Hygiene.
Item 27 is marked other then "naturel", or Iteme 23s or 28e-f ehow other traumatic event, the Medical Examiner must be intillied at 1 Yes 2 No Baltimore Knottingham Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 MOH ourt Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 → Kes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 72 hours after 1 Never Married 2 Married Black 1 Tes 2 No Specify: Specify: ð Maryland 21215-003 3 Widowed 4 Divorced **Be Completed** 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer State of MD NIA 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
importent: If tem 27 is marked othe
eny injury or other traumatic event,
once. 17. Father's Name (First, Middle, Last) Joseph H. Stokes, Sr. Conigland alvia 19b. Mailing Address (Street and Number or Rural Route Number, Sity or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Court Knottingham MD 21 Wolftrap WIFE Michelle D. 21236 Stokes 2dc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, 20a. Method of Disposition 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD Garden of Faith 05.01.06 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Youghn C. Greene Funeral Services
4700 York Road Baltimore MD 21212 21. Signature of Funeral Service Licensee > luc Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) Flioblaston **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ste hes been signed by the page 2 should be detached 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No this certilicate of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No ٩ 1 Yes To the Hospital or Attending Physwithin 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certile 29d. Date signed (Month, Day, Year) 29c. License number 2006 D-51555 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Auno egistrar's Signature 31. Date filed (Month, Day, Year) 32 State APR 2 8 2006 Registrar

3403 State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Doris E. Slater 4/24/2006 6:30pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood Center Baltimore N/A If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 11/12/1909 Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Months 1 □ M 200 578-42-0237 ND Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b County r than "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at N/A 1**∑**Xes 2 □ No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 311 E Cross Street 21230 USA within 72 hours after deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: Š 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Hygiene. other than " Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Grocery Business Exec. permit. Pages 1 and 2 should be filed with Depertment of Health and Mental Hygien important: if Item 27 is marked other that any injury or other traumatic event. Insulp. 2008. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur W. Wilke Anna M. Dill ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sheldon H. Slater / Nephew 311 E. Cross Street, Baltimore MD 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem. May 1, 2006 Suitland, MD 4 □Donation 5 □Other (Specify) Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Ecensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the burial-transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physicien Physician/Medical as signed by the ettending d be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Records. 1 Yes 2 No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2-2 No 1□ Yes of Vital After this certification 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification; To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director; Afte completely filled in by the fune. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ATTENDING PHYSICIAE 00 6003 DA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) March 00 BLUD POBT 30 LOCK KAUGN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 8 2006

DHMH 17 Rev 1/2001

ORIGINAL

		•	- For Amend Ite	State of Maryla 26 per Dr.,	854, Oep	artment of F 28/06dhb rtificate of	lealth and N Death	fental Hyg	iene 0 0 6	3404
			1. Decedent's Name (First, Middle, L					2. Date of Deat Month		3. Time of Death
_	Physic /Medi		JOAN	M		S	HAW	APRIL	24 2006	3.4
	Exami		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	ath
			3021 FALLSTAFF		to at himbor.	BALTIMO If Under 1 Year	RE If Under 24 Hrs.	9 Date of Birth	N/A	
	Funeral		5. Social Security Number 6. 217-20-6346	Sex 7. Age (In yi	rs. last birthday) 78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 02/04/19	Year)	rthplace (State or Foreign Country) MD
	Director		Usual Residence of Decedent	۸	70			02/04/13	120	עויו
	death with the Marylend me 23a or 28a-f ehow rmust be notified at	ō	10a. State 10b. County	N/A 10c.	City, Town or Lo					10d. Inside City Limits 1 Yes 2 □ No
	28a-1	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What 0	Country?
	with Ba or	ā	3021 FALLSTAFF	ROAD #308		21	209		U.S.A	
	me 2;	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh	
	ㅎ 르 등	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		1 Yes 2 No	Specify:	rioari, otc.,	Specify:	WHITE
	Maryland 21215-0036 d 2 should be filed within 72 hours atter th and Mental Hygiene. 77 is marked other than "naturel", or lie traumatic event, the Medical Examina	Completed	15. Decedent's (Specify only highest of	grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work		16b. Kind of Busines	s/industry
	d withing d withing giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4	TEACH	HER			EDUCAT	ION
•	nd 2.	Be	17. Father's Name (First, Middle, La		ACULTNO	-n		e (First, Middle, M		TI VEDMANI
	larylan 2 should be and Mental Is marked o	ဥ	MILTON		1EHLING		MYRTLE			ILVERMAN Zie Godel
	Mar 12 sh h and 7 ls m	1 7	19a. Informant's Name/Relationship						City or Town, State	
-	the see		MORTON SHAW / H 20a. Method of Disposition	USBAND 20t	. Place of Disp	osition (Name of			IMORE, MD 20c. Location - City of	
p	nor nor nor nor nor nor nor nor nor nor		t X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□Removal from State	•	matory or other pla E HEBREW	1	/2006 R	EISTERSTO	WN_MD
25	Baltimore, permit. Pages 1 e Depertment of Hee important: if item eny injury or othe		21. Signature of Funeral Service Lic			2. Name and Addre	es of Facility		ON & BROS	
7	m ggggg		Kolito)	ohm -		3900 REIS	TERSTOWN	ROAD - P	IKESVILLE	
7			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the dealy one cause on each line.	eath. Do not en	ter the mode of dy	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Lvn	9 Car	CEL				montes
1.10	/Medical Examiner		resulting in dealin	Due to (or as a cons	sequence of):					
12	, K	ē	Sequentially list conditions, if any, leading to immediate	b. Due to for as a cons	saquanca of).					
47	Recuted and I-transit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	с.						
9	760, e be executed sicien and e burial-transit	EX	resulting in death) Last	Due to (or as a cons	sequence of):					
0	8760 cate be e physicien the buris	dicai		d						,
4,2	I Records, P.O. Box 68760,  The law requires thet the death certificate be executed as hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etai death 3	□Ectopic pregnand	у		23d. Date of d	elivery Day Year
-	P.O. I	ysic	1 □ Yes 2 🕅 No 9 □ Unknown	4☐Pregnant at time o	or death 5	Other (specify) _				
-	s thet the	by Ph	Part II. Other significant condition	s contributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
4pr	cords, w requires been sign should be	ed						1 X Y	es 2 No 3	Probably 4 Unknown
4	Records, he law requires t e hes been signe age 2 should be	Completed						24a. Was a autops	y prior t	autopsy findings available o completion of cause of
000		Com						performula 1 Tes	med? death' 2.021No 1.□Yo	? es 2 No
haw	Vital sicien: T certificet	Be	25. Was case referred to medical examiner?	Hospital:			hac	th (Check only or		la - 0 ^
2	Of \Physical Physical direction	6	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	28b. Time	AIL SOLDON	4 Unitality in		ence 6 A Other (S)	pecify) NOSPICE
5	ding I	ig E	1 Natural 5 Pending 2 Accident investiga	(Month, Day Year	r) Injury	Wo	ork? ]Yes 2 []No	200. 2000.	,,	
>	Division I or Attending after death. Director: Afte	fica	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury - A		treet, factory, office		28f. Location (S City or Town	treet and Number or	Rural Route Number,
an	Divine a Divine ed in 1	Certification:	4 C Hornicide	building, etc. (Sp.	ecity)			Ony or Toll	., 51410)	
B	Division of Vita virinity Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification completely filled in by the funeral director.	edicai	29a. Certifier 1 S Certifying (Check only 2 Medical E:	Physician: To the best of my maminer: On the basis of exam and manner stated.	knowledge, dea nination and/or i	ith occurred at the t nvestigation, in my	ime, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	<i>.</i>		_	se number		Apac 2!	
	1		Ancar	l-us		νS	0 >0 >		711-00 2	
	10		30. Name and address of person w		Item 23a) (Type 0 ( /V-	CHANUES	ST BR	nure	us 20	204
,		tate	31. Date filed (Month, Day, Year)	32/Registrar's S	ignature	alle				
	Regis	trar	APR 2 8	LUUD JAMENES	20 80					

State of Maryland / Department of Health and Mental Hygiene 3405 1- State Registrar Amend Item 26 per Dr., G854, Oct 28/Oct Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Year APRIL 27, **Physician** 1:35 A STEINBERG JACK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE 6317 PARK HEIGHTS AVENUE #203 ff Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08/06/1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F PA 76 191-22-9540 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State rel', or itema 23a or 28a-f ehow Exeminer must be notified at 1 ¥ Yes 2 No BALTIMORE N/A Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 6317 PARK HEIGHTS AVENUE #203 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No 49/50 If Yes, Give 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coflege (1-4or 5+) EDUCATION **PROFESSOR** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SNOWHITE STEINBERG ANNA DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Refationship (Type, Print) 6317 PARK HEIGHTS AVE. #203 - BALTIMORE, MD 21215 LIBBY STEINBERG / WIFE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ance. SHAAREI ZION CEMETERY 04/27/2006 ROSEDALE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Educated Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ûı 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) NNG Cancel **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 X/No 2 □ No 1 Yes 1 Tyes or Attending Physician: neral Director: After this certific tilled in by the tuneral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Division 1/ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 27 2006 1)58303 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) BARMORE MD 21204 CHALLES MD 6601 N. Chiviss 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) RACHES 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 13405 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 24, Day 2006 1:16 P **Physician** SHAPIRO ELLEN NANCY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY BETHESDA SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 06/26/1934 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 ☑ F PA Yrs. 71 578-44-6333 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count worle other then "natural", or items 23s or 28s-f shovent, the Medical Examinar must be recitified at 1 ☐ Yes 2 No BETHESDA MONTGOMERY Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20817 7401 WESTLAKE TERRACE #1116 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) FEDERAL GOVERNMENT MEETING PLANNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental H tant: if Item 27 is marked off jury or other treumatic even ROSENBLATT SARA UNOBTAINABLE MORRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7401 WESTLAKE TERRACE #1116 - BETHESDA, MD 20817 ALVIN SHAPIRO / HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o important: if eny injury or once. JUDEAN MEMORIAL GARDENS 4/27/06 OLNEY, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. permit. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tear **Physician** OVARIAN CANLER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificete be executed ete hes been signed by the ettending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No м death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kali WILHOLIW YZY AVANUE # (300, CHEVICHAIE, MD 20815 SON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 Registrar

**ORIGINAL** 

06-02736 John Sachs

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		e of Death		Reg. No.	5 1340					
Physician/ Medical Examine		R.	SACHS	2. Date of Dea Month April 22, 2	Day Year	3. Time of Death 1533 hrs					
· ·	4a. Facility Name (if not institution, give street and number) Sinai Hospital	)	4b. City, Town, or Location Baltimore City	on of Death	4c. County of Death	N/A					
Funeral Director	219-60-9770 1XM 2F	ge (In yrs. last birthda	ay) If Under 1 Year If Under 1 Year Yrs. Days Ho	ure Min	rth(MM/DD/YYYY) 9 Bir /1954 Foreig						
any	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or	Location			10d Inside City Limits					
Aaryland 28a-f show 1 at once. ector	FL DADE	AVENT	URA 10f. Zip Code	<del></del>	10g Citizen of What Coul	1 X Yes 2 No					
h the Maryland 3a or 28a-f sh totified at ones			33:	180		USA					
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once Be Completed by Funeral Director	Never Married / V Married	X No	3. Was Decedent of Hispanic Elf Yes, specify Cuban, Mexic  1 Yes 2 X No specify Cuban, Mexic  1 Yes 2 X No specific Section 1.	an, Puerto Rican, etc.)	5- 14 Race - Ameri White, etc.	can Indian, Black,					
ours aft	15. Decedent's Education (Specify only highest grade cor	npleted) 16a. De	cedent's Usual Occupation (Gring most of working life. DO NO	ve kind of work done	16b. Kind of Business/I						
11215-0036 Id be filed within 72 he dental Hygiene. narked other than "mevent, the Medical Exposure. event, the Medical Exposure. De Be Complete	Elementary/Secondary (0-12) College (1-4 or 4	5+) OWN	IER			MANAGEMENT					
ID 21215-0036 ID 21215-0036 Ib 21215-0036 and Mental Hygiene. 77 is marked other than matic event, the Medical TO Be Comple	Tr. Tasior o Harrio (Frior, Milato) Casty	SAC	1	ner's Name (First, Middle, MADELAINE		KETZKY					
7 5 5 E 2 O			Mailing Address (Street and No. 85 E. COUNTRY								
≥ 월설일립	20a Method of Disposition	20b. Place of D	Disposition (Name of cemetery, or other place)		20c. Location - City or						
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	1 X Burial 2 Cremation 3 Removal from St 4 Donation 5 Other Specify:	ate	RIDGE CEMETERY			ESVILLE, MD					
Bal: permit Depar Impor	21. Signarare of Funeral Service Ligensee		22. Name and Address of Fac 8900 REISTEI		INSON & BRO - PIKESVILL						
Physician /Medical	23a Parvi. Enfer the disease or complications that caused failure. List only one cause on each line.		1980 Setting 30	0.0		Approximate Interval Between Onset and Death					
xaminer	Immediate Cause (Final disease or condition resulting in death)  a Complications of right subdural henor have associated with lembhil Due to (or as a consequence of):  Sequentially list conditions,										
Je.	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause	e‡ience of):									
ted Insit Examî	(Disease or injury that initiated	(Disease or injury that initiated									
760, icate be executed the burial - transit //Medical Ex	X UNPENDED AMENDED it	cem#23a,27,2	8a-f,perME,g855,5	/1/06 TT							
Ox 68 ath certif attending or use as	past 12 months?  1	me of pregnancy  2 t time of death 5	Fetal death 3 Ecto Other (Specify)	ppic pregnancy	23d. Date of delivery Month	day Year					
P.O. Be so that the degree by the edetached for by Physical By Physical By Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical	Part II. Other significant conditions contributing to deat	h but not resulting in	the underlying cause given in		obacco use contribute to						
ords, P.C. w requires that s been signed should be detected				1 Ye	s 2 No 3 Prob	topsy findings available					
Division of Vital Records, not outerding Physician: The law require rs after death at Director: After this certificate has been sixted in by the funeral director, page 2 should be retification: To Be Completed					prior to death?  No 1 V	ompletion of cause of					
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner?		Other	th (Check only one)							
n of Vi ling Physi After this funeral dir	1 V Yes 2 No 27. Manner of Death 28a, Date of Inju	ent 2 🗸 ER/Outp	atient 3 DOA Other 4 ne of Injury 28c. Injury at We		Residence 6 Other						
Sion Attendia death setor: A yy the fu	Natural 5 Pending April 22 X Accident Investigation	2, 2006 unk	1 Yes 2								
Division C To the Hospital or Attending within 24 hours after death To the Funeral Director: Af completely filled in by the fun ledical Certification	3 Suicide 6 Could not be determined (Specify)	NOUSE	, street, factory, office building,	etc. 28f. Location ( or Town, S Baltimore	Street and Number or Ru State) 111 Hamlet . MD	Hill Road					
To the Hos  within 24 h  To the Fun  completely	29a Certifier										
L F S F S W	29b. Signature and title of certifier	er 29d. Date signed (Month, Day, Year) April 23, 2006									
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	30. Name and address of person who completed cause of o	death (Item 23a)	O.C.M.E.		, tpin 20, 2000						
	Ana Rubio MD. Assistant Medical Exan		nn Street, Baltimore, M	D 21201							
State	31. Date filed (Mon A, PR Year) 8 2006 32. registra	ar's Signature									

			1 - For State Registrar		ryland / Dep <i>Ce</i>	artment of F		lental Hygie	4000	13408
	° Physic	ian	Decedent's Name (First, Middle, I	.ast)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Jeanette	L.	•	Tay.			24 2006	3:57 PM
	Exami	ner	4a. Facility Name (If not institution, g	•			r Location of Death		4c. County of Deat	h
		E.,	Sinai Hospital d				ine City			
	Funeral Director		5. Social Security Number 6. 214-80-9495 Usual Residence of Decedent		(In yrs. last birthday)  17 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 09 06	9. Birtl Co	nplace (State or Foreign untry) MD
	fand ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f ahow Irrust be notified at	tor	MD Balti	more	Ess	еx				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	s 23E	al	1007 Walnut G	rove Road		2	1221		U.S.A.	
		Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	ncan Indian,
9	or it	J.	1 Never Married 2 X Married	1 Yes 2 No If Yes, Give Year or Dates:	•	1 ☐ Yes 2 ☐XNo	Specify:	rican, etc.)	Black, White	
8	72 hours after natural', or ite	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: B	3lack
<u>7</u>	hin 72 h e. en "natu Me lical	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Dece	dent's Usual Occup	ation during most of work d)	ing 16b	. Kind of Business/I	ndustry
12		ш	Elementary/Secondary (0-12)	College (1-4or 5+	, ,		1)		Munaina	II a m a
2	iled Hygi Int,	ပိ	12th grade  17. Father's Name (First, Middle, Las			Nurse	40.14		Nursing	поше
ä	\$ 5 5 5 5	Be						e (First, Middle, Maid	den Sumame)	
Ž	2 should be f and Mental I Is marked of raumatic eve	ဥ	William L. Sm		211		Mable F			
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 la marke other traumatic	1 3	19a. Informant's Name/Relationship					al Route Number, Ci		
	permit. Pages 1 and 2 Department of Health s Important: If item 27 li any injury or other tra once.	1	Robert M. Simm  20a. Method of Disposition	ons-Husbar	20b. Place of Dispo			Baltimo		21216
Baltimore,	ages in of l		1 Burial 2 Cremation 3 1	Removal from State	cemetery, crer	natory or other plac	e)		. Location - City or T	
Ξ	t. Partment							'26/06 Ba	altimore	, Md
Bal	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	ensee	, M.	Name and Address F/F	ss of Facility H West			
			1 Juneta	Ch Ji				Baltimo	ore, Md	21215
*	cate be executed /Medical Examiner the burial-transit	dical Examiner	23a. Pant1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any least the cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Res Due to (or as a of	piratory D	-				Interval Batween Onset and Death 2 days + days
P.O. Box 68	the death certifi by the attending ached for use as	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □Live birth 2   4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
s,	ires that signed b	by P	Part II. Other significant conditions	contributing to death but	not resulting in the un	derlying cause give	en in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
Records,	w require been si should?	ed	AIDs					1 🗆 Yes	2 □ No 3 □ Prot	bably 4 DUnknown
သို့	≥ <u>0</u> v	Completed						24a. Was an	24b. Were auto	opsy findings available impletion of cause of
<u> </u>	iclan: The taw r certificate has be rector, page 2 sh	E						autopsy performed?	death?	
Vital	an: rtiffice stor. p	0	25. Was case referred to medical				26. Place of Death	(Check antivaria)	No 1 ☐ Yes	2)2 No
>	g. ∞. <b>X</b>	To B	examiner? 1 ☐ Yes 2 ∰No	Hospital: 1 Inpatient	2 ER/Outpatient	3 DOA Othe		ne 5 Residence	6 Other (Special	6-1
	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury Work	at 2	8d. Describe how in	jury occurred	<i>y</i> )
<u>.</u>	Attending It death. ector: After by the fune	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		ea <i>r)</i> Injury		es 2 □No			
Division	s after de safter de la Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		- At home, farm, stre Specify)	eet, factory, office	2	8f. Location (Street City or Town, Sta	and Number or Rura ate)	al Route Number,
:	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 ★ Certifying Pl (Check only one) 2 ★ Medical Exam	nysician: To the best of miner: On the basis of ex and manner stated	amination and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)
	With:	Σ	29b. Signature and title of certifier			29c. License		29d. E	ate signed (Month,	Day, Year)
	0		Bax -	- PO		RES	-000	An	11 24,20	06
1	) 1		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type, F	rint)		-		
0	L		Carolyn K.	Wang, DO	Sina: +	lospital i	of Baltin	ore		
	Stat Registra		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	all)				

Jeanette Taylor

iditient Known as

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item# 4b-c,pen/W. C855,5/9/06/JT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend Item/1,19a&20c Per Physical Control of JH Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL Year

Mae Terry

4b. City, Town, or Location of Death

21215

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

08

2Ó

Randallstown

10f. Zip Code

Ethe1

7. Age (In yrs. last birthday)

10c. City, Town or Location

Baltimore

TCOSPITAL

3. Time of Death

Birthplace (State or Foreign Country)
 NC

Black

21215

Approximate Interval Between Onset and Death

Year

10d. Inside City Limits 1 Tyres 2 □ No

2000

4c. County of Death

Baltimore

10g. Citizen of What Country?

U.S.A.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

18

2006

MD 21133

Month

14. Race - American Indian. Black, White, etc.

9:00 A M

			. For	ICCIII 4D	C ,	'State	SPM
			_ State	end Ite	200/	#1.19a	\$20c
			1. Decedent's Name				
	Physici /Medic		ETHE	_ 7	E	PRY	<u> </u>
}	Examin		4a. Facility Name (I	f not institution,	give	street and n	umber)
			KOR	THWE	57	to	20
	Funeral		5. Social Security N	umber	6. Se		7. Ag
в	Director		246-46-		1 [	□ M 2 🔀 F	
	ъ		Usual Residence of	Decedent			
	Han Han		10a. State	10b. County			
	od within 72 hours after death with the Maryland gjene. er than "neturel", or Items 23e or 28e-f show i, Ire Medical Examirer must be notified at	Funeral Director	MD	N.	4		
	h th or 28	ire	10e. Street and Nur	mber			
	23e c	aiD	4406 Fe	rnhill	L,	Ave	
	des	ne	11. Marital Status			12. Was Dec	cedent
9	affer all the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se	E	1 Never Marri	ied 2□ Marne	d	1 ☐ Yes	3CX
8	rel', o	by	3X☐ Widowed	4 Divorced	į	If Yes, G Year or	Dates:
15-0	n 72 hours after death with the Mar "neturel", or Items 23e or 28e-1 sh solical Examiner must be notified	etec	(Spec	15. Decedent's			")
21215-0036	ad within /giene. ier than t, ine Ma	Completed	Elementary/Seco		College na	(1-4or	
14	0 0 0	Ó					

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specity: 3X☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service oth grade na Custodian permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Importent: If item 27 is marked other eny injury or other treumetic event, III ODGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) Baltimore, Maryland @Frank Carroll Alice Brodie 19a. Informant's Name/Relationship (Type, Print)

Dorothy Terry

Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4406 Fernhill Ave, Baltimore, Md 20b. Place of Disposition (Name of cametery, crematory or other place)

Jones Chapel Bapt 4/25/06

Norlina
Nolina, 20c. Location - City or Town, State Norlina 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Church Cemetery 4/25/00 NOTING,

22. Name and Address of Facility
March F/H West

4300 Wabash Ave, Baltimore, Md Funeral Service Licensee 21. Signature 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line! mmedate Cause (Final disease or condition less ting in death) ASPIRA PNEUMONIA **Physician** TION /Medical Due to (or as a consequence of): Examiner EMBNIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. the igned by the bed tach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24a. Was an autopsy performed? ate has I page 2 s certificate 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Thpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔁 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 254352 0 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINCEA TODOR NORTH WEST FLOSPITAL SHOLOLD COURT ROAD RANDAUSTOWN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 21 April 2006 2215 Allen Turner /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1XM 2□ F 59 Yrs. 212-42-1878 Director 3 1946 Maryland June Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Madical Examiner was be notified at 1XX es 2 ☐ No Annapolis Maryland Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 823 C Betsy Ct. 21401 USA or items 23a 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ 3 Widowed 4 Divorced naturei Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. important; if item 27 is marked other than any injury or other frammer. Elementary/Secondary (0-12) College (1-4or 5+) Turner's Tile Co. Tile Setter 9th n 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Allen Turner Viola Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 823 C Betsy Ct. Annapolis, Md. 21401 Roxanne Turner(Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ebenezer AME Church 5-2-06 XXBurial 2 Cremation 3 Removal from State Galesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Larry B 1. Reese MODY West St. Annapolis, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 30 in 1 -Physician Cardia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 20 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 1 Yes 2 No 1 🗌 Inpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manngrof Death 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only опе) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D002549 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1460 ) Amas chie MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 06 Lex /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5310 Gwynn Oak Avenue Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04 DI 1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Hours 78 Yrs. 238.40.6740 1 M 2 □ F NC Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ul Hygiene. I other than "naturel", or Items 23a or 28a-f ehow vent, Ite Medical Exercit set rivest be ricitied at Baltimore 1 Mes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 5310 Gwynn Oak Avenue 21257 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 De No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Masonn FINISHER Cement 11th grade 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumetic event, once. 17. Father's Name (First, Middle, Last) Be Powell 1-1110+ 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael S. Taylor, Balto, MD 21207 Nephew 5310 GWYNN Dak Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■Burial 2 Cremation 3 Removal from State 04.29.06 Baltimore MD Western Star 4 ☐ Donation 5 ☐ Other (Specify) Compassion Funeral Services 119-1215. Stricker Street Baltimore MD 21223 21. Signature of Funeral Service Licensee ê 23a. Part Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ANCEK Momo /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2XNo 1 🗌 Y*e*s 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Manner of Death 5 Pending investigation 1 Accident sefter death.

I Director: All
d in by the fur 1 🗌 Y*e*s 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD person who completed cause of death (Item 23a) (Type, Print) Edmondson 30. Name and address 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINA

2006

			For State Registrar	State of Ma		ertificate of E			g. No.	13416		
	Physici /Medic		1. Decedent's Name (First, Middle, Albert		Sr.			2 Date of Death Month April 1	Day Year	3. Time of Death 5:00am м		
	Examin	_	4a. Facility Name (If not institution, g Fort Washingto			4b. City, Town, or	Location of Death		4c. County of Dea Prince G			
	Funeral Director		435-28-5442	.Sex 7.Age 10XFM 2□F	(In yrs. last birthda 92 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 1, 19	9. Bir 914 St. J	thplace (State or Foreign puntry) ames Parrish, LA		
	anyland show	ž	Usual Residence of Decedent  10a. State 10b. County  LA Orlea	ans	10c. City, Town or	Location Orleans				10d. Inside City Limits 1   Yes 2 □ No		
	with the M a or 28a-f	Directo	10e. Street and Number 1201 Columbus	Street	1,0,1	10f. Zip Code 7011	 16	10	og. Citizen of What Co	ountry?		
336	be filed within 72 hours after death with the Maryland ital Hygiene.  dother than "netural", or Itams 23a or 28a-f show event, I'm Medical Exartinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	Ever in U.S. 1	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify: B			
21215-0036	within 72 horiens. Than "neture the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5-	(Gi	cedent's Usual Occupa ve kind of work done d b. DO NOT use retired) Laborer	uring most of worl	king	Agricult			
Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be C	17. Father's Name (First, Middle, La Alex Theriot					ne (First, Middle, M 1 Edwards				
	ges 1 and 2 should t of Health and Men If item 27 is marke or other treumatic		19a. Informant's Name/Relationship Ethel Porche / 1		68	illing Address (Street a	ith Road	Carner, N	4S 39426			
Baltimore,	Par Par Par Par Par Par Par Par Par Par		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	ocity)		position (Name of rematory or other place cemetery  22. Name and Addres	UNK.	Date 2	Metairie, I.A			
Balt	permit. Departr imports eny inj		21. Signature of Fuheral Service Li	me Inc. MD 21230								
	Pnysician		23a. Part1. Enter the disease or c shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	SEPTI	C SHO		g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death UNKNOWN		
	/Medical Examiner	٦.		EMPSEMA	s consequence of):  STATUS a consequence of):	POST CHES	T TUBE A	LACE MEX	IT	UNKHOWH		
oʻ.	ificate be executed g physicien and as the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. POST OBSTRUCTURE PNEUMONIA  Due to (or as a consequence of):  d. STREPTOCCUS PNEUMONIA WITH BACTEREMIA  UN								
68760,	ficate be physicie s the bu	edicai		STREPTO	ccus ph	EUMONIA	WITH BA	CTEREMI	4	UNKNOWH		
Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	olivery Day Year		
I Records, The law requires it are has been signe page 2 should be d		þ	Part II. Other significant condition  METASTATIC	_		a underlying cause give	en in Part I.		oacco use contribute t os 2 □ No 3 □ P	o the cause of death?		
									y prior to ned? death? No 1 □ Ye	utopsy findings available completion of cause of s 2 No		
	g Physician: ler this certificater, heral director,	n: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 XInpatie 28a. Date of Injur	y 28b. Time	of 28c. Injury	⁹ F: 4 ☐ Nursing H		e) ince 6 □Other ( <i>Sp</i> e ow injury occurred	ecify)		
Division of tall or Attending F states death.  al Director: After ed in by the tuner.  Contification:			2 Accident investiga 3 Suicide 6 Could no	2 Accident investigation investigation 2 Security of Column 1 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security of Column 2 Security o								
	Hospita 4 hours Funsral ely filled	Medical Ce		Physician: To the best of xaminer: On the basis of and manner sta	examination and/or							
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of Certifier	(Co		29c. License	1262 1262	29	9d. Date signed (Mon	th, Day, Year)		
(	57		30. Name and address of person DR . SAMUEL J.	the completed cause of d	eath (Item 23a) (Typ			lingston R	d., Ft. Wasi	h., MD.20744		

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
APR 2 8 2006

			1 - For State Registrar	-	of Marylan	d / Depa		t of H	ealth a		•		•	13413
	Dharini		1. Decedent's Name (First, Middle, Las	1)							2. Date of De		Voor	3. Time of Death
	Physici /Medio		Mary Ann Wasiuk								April	26,	200er	6:45 A M
	Examir		4a. Facility Name (If not institution, give	street and nu	ımber)		4b. City,	Town, or	Location of	of Death		4c. C	county of Death	
			Frederick Villa N				Cato						ltimore	<u> </u>
	Funeral Director		5. Social Security Number 6. Security Number 007–09–3359 Usual Residence of Decedent	x □M 21K0F	7. Age (In yrs. 92		If Under Months	1 Year Days	II Under Hours	Min.	8. Date of Bi (Month, Da Jan 8,	1914	9. Birth Cou Main	place (State or Foreign ntry) e
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-						10d. Inside City Limits
	Man,	tor	Maryland Baltimore	<u>.</u>		Catons	ville	:						1 ☐ Yes 2 🛣 No
	or 284	lrec	10e. Street and Number				10f. Zip	Code					en of What Cou	
	23a	ral	30 S. Prospect Av	enue			212						d State	es
9	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or iteme 23e or 28e-f ehow other traumatic event, the Micinal Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marned	Armed F	2 X No	1	Was Deced fYes, spec 1 ☐ Yes 2			gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	1	4. Race - Amer Black, White Specify: Tab	etc.
8	urel',	d b	3 ☑ Widowed 4 ☐ Divorced	Year or I	Dates:								AATT	ite ——————
7	n 72	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed,	)	16a. Deced	ient's Usua kind of woi DO NOT us	k done d	luring most	t of worki	ng	16b. Kin	d of Business/Ir	ndustry
77	iene.	omb	Elementary/Secondary (0-12)	College (	(1-4or 5+)	wea						ma	terial	
פ	al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden S	iumame)	-
Vai	Menta Menta arked	To	Andrew Varasky						Mary	y Ger	boc			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (7		2.1		-					-	Town, State, Zi	
<b>6</b>	1 and Health In 27 Ther t		Diane C. Magersup	o – dai							oate Cat		ation - City or T	ryland 2122
Baltimore,	permit. Peges 1 and Department of Healimportant: If Item 2 eny injury or other 0000.		1 XBurial 2 ☐ Cremation 3 ☐			Place of Dispo emetery, crer w Cathe			9)   M					Maryland
	artme ortan injury		4 □ Donation 5 □ Other (Specify  21. Signature of Juneral Service Licen		INC				1				Home,	
8	Depa impo eny i		Inn Ke	we	/								•	ind 21229
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ne cause on	each line.			ol dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		um	no							i wech
	Examiner			Due to	(or as a conseq	uence of):								
	ķ	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	uence of):								
	cuted nd ransit	Examiner	that initiated events	С.										
760,	e be executed /sicien and e burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):							1	
6876	ate b	dlcal	•	d										
	ding page as	/Me	IF FEMALE:	720 If you o	stanma of program									
P.O. Box	Attending Physician: The law requires that the death certificate be executed rideath. sctor: Atter this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	atcome of pregna birth 2 ☐ Feta nant at time of de nown	Ideath 3□	Ectopic pro Other (spe				JD	23	d. Date of deliv Month	ery Day Year
	signed by deta	by Pl	Part II. Other significant conditions co	ntributing to d	leath but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did 1	obacco us	e contribute to	he cause of death?
ğ	w require been sig should b										1 🗆	Yes 2	NO 3 □ Pro	bably 4 Unknown
Records,	law ras be	Completed									24a. Was		24b. Were auto	opsy findings available ompletion of cause of
= =	The	Con									perfo 1 ☐ Yes	ormed? 2€1√0	death? 1 ☐ Yes	
Vital	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	F		(Check only			
ot	Phys this ral dir	٠ <u>۲</u>	1 ☐ Yes 22 Mo 27. Manner ol Death	28a. Date	of Injury	ER/Outpatien 28b. Time of			4 2 140		ne 5 Resi		Other (Speci	fy)
Division of	tending leath. tor: After the fune	Certification:	1  Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Mor	nth, Day Year)	Injury	М		? ′es 2 ☐ !	No				
<u> </u>	al or At s after o	SertIf	4 Homicide determined	289. Plac	e of Injury - At ho ling, etc. <i>(Specif</i> )	ome, farm, str y)	eet, lactory	, office		1		Street and wn, State)	Number or Rur	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier (Check only one) 1 ☐ Certifying Phyone) 2 ☐ Medical Example 1	iner: On the b	e best of my kno basis of examina oner stated.	wledge, death tion and/or in	occurred a restigation,	at the tim	e, date an	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner as s place, and due t	stated. o the cause(s)
	To the Within To the comple	Σ	29b. Signature and tifle of certifier	S			29c	License	number 34	957	,	29d. Date	signed (Month,	Day, Year) 200 C
6	1		405 Kelerch	Re		100	Print) C	An	00./	1/4 .	10	7122	V	2006
	Sta		31. Date filed (Month, Pay, Year) APR 2 8 2	006 32.	gistrar's Signa	itura	0	IR.						
DH	Registr MH 17 Rev 1/2		7011 0 2	000	10 10 J	0.				-7.0=		- 5		-

ORIGINAL

			1- State of Maryland / Department of Health ar Certificate of Death	nd Mer		iene () ()	16 34	Descent Inches
H	Physici		Decedent's Name (First, Middle, Last)     WILLIAM BERKLEY WILLIS	2.	Date of Dear Month,	Day	Year OOS	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of I UNION MEMORIAL HOSPITAL BALTIMORE	Death		4c. County o		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24	4 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birthplace (State or Fo	
	g		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	A	pril 3	,1920	North Caroli	
	death with the Maryland ima 23a or 28a-f ehow r must be notified at	ctor	Maryland Baltimore Baltimore County				1 ☐ Yes 2 💆	
	3a or 24	i Dire	10e. Street and Number 10f. Zip Code 21236		1	0g. Citizen of W	hat Country?	
S S	s after death , or items 2 eminer mun	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married XXX Married  12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 X Yes 2 No 1 Yes Size I/V No Specify:	in? (Specify Puerto Ric	y Yes or No- can, etc.)	Black	- American Indian, c, White, etc. White	
1215-0036	be filed within 72 hours after death with the Marylan delity typiene.  I delity giene.  I d	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	of working		16b. Kind of Bus		•
Maryland 2	2 should be filed w and Mental Hygie Is marked other ti raumatic svent, ID	To Be Co		's Name <i>(F</i> h Dav		Maiden Surname	a)	
Mary	A = V =		19a. Informant's Name/Relationship (Type, Print)  Lorraine Willis (Wife)  19b. Mailing Address (Street and Number of Street and Number			-	State, Zip Code) 21236	Ÿ
nore,	ages 1 and of Heeling 1; if Item 2		20a. Method of Disposition  XXXXBurial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date			City or Town, State	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite eny injury or ot		21. Signarure of Funeral Service Lice (see	Home		Saltimor		
			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock or heart failure. List only one cause on each line.	Balt. ardiac or re	imore, espiratory arr	Md. 212 est,	Approximate Interval Between	n
	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)  a. Cardin my lating  Due to (or as a consequence of):				Onset and Deat	th
	Examiner	er	Sequentially list conditions b. Pulmonary Hyperten	sien	`			
,	icate be executed physicien and s the burial-transit	Examiner	fliarly, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
P8/P0	icate be physicie s the bur	dicai	d					
C. Box	or the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐			23d. Date Mon	of delivery th Day Year	,
ds, P.	as the gned	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				bute to the cause of death	
Hecord	e law has b	Completed			24a. Was a autops	or pr	Vere autopsy findings avairior to completion of cause	lable e of
VIta	iclan: The certificete hi rector, page	Be Co	examiner?	of Death (C		2 No 1	Yes 2 No NA	
0	Phys this ral dir	n: To	1 Yes 2 No Hospital: 1 Inpatient 2 YER/Outpatient 3 DOA Other: 4 Nurs  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			ence 6 Other		
DIVISION	Atten r deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined of the could not be determined.		. Location (S	treet and Numbe	er or Rural Route Number,	
בֿ	Hospital or 24 hours efte Funeral Dir tely filled in I		29a Certifier 1 Certifying Physician: To the best of my knowledge death oppured at the time date and	place and	City or Town	nusals) and man	nner se etaled.	
	To the Hospital within 24 hours e To the Funeral completely filled	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	h occurred	at the time, d	ate and place, a	nd due to the cause(s)	
1	7		I to \$700 mg Attending Physician D 600	581		April	26,2006	
	12		29b. Signature and title of certifier  29c. License number  20c. License number  29c. License number  29c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License number  20c. License	Park	way	Baltim	ore MD 212	-18
	Sta Registi		31. Date filed (Month, Day, Year)  32. Régistrar's Signature		ر			

		1 - For State Registrer	State o	f Maryla	nd / Depa <i>Cei</i>	artmer rtifica:	nt of H te of L	ealth a D <i>eath</i>	ınd M	ental Hy	giene Reg. No		13515
6		1. Decedent's Name (First, Middle, L.	ast)							2. Date of De	ath		3. Time of Death
Physic /Medi		Margaret Fowle	er Will	iams						April	26,		1:30 A M
Examin		4a. Facility Name (If not institution, gi					, Town, or	Location of	f Death			County of Death	1
No.	, e	Manor Care Nur					Rossu					Baltim	
Funeral		1	Sex 1 □ M 2 ☑ F	7. Age (In yrs	s. last birthday) Yrs.	Months Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth Cou	npface (State or Foreign untry) Virginia
Director		Usual Residence of Decedent	^	7.3	113.					April	28,1	912 West	Virginia
yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. fnside City Limits
Mar Be-f st	į	Maryland Baltime	ore		Essex								1 ☐ Yes 2 No
th the	ire	10e. Street and Number				10f. Zi	p Code				10g. Cit	izen of What Cou	untry?
23a	Ta I	2216 Park Drive	2					2122	?.1		u.s.A.		
er de	Funeral Director	11. Marital Status	12. Was Dece Armed Fo	rces?	U.S. 13. V	Was Dece f Yes, spe	dent of His	spanic Orig n, Mexican,	in? (Spe Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - Amer Black, White	ican Indian, , etc.
rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or D	9	1	1 □ Yes	2 <b>X</b> ) No	Specify:			Specify: White		
21215-0036 ad within 72 hours aff giene. or then "naturat", or it in Mudical Exerti	ed	15. Decedent's E	ducation		16a, Deced	dent's Usu	al Occupa	tion			16b. Ki	nd of Business/li	ndustry
215	pie	(Specify only highest gr Elementary/Secondary (0·12)	ade completed) Colfege (1	-4or 5+)	(Give	kind of wo	ork done d ise retired,	uring most	of working	ng			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
24 with gienre	Completed	12	oonogo (	401 347	H	omemo	aker					Own Hor	ne
Ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturat", or items 23a or 28e-f show event, the Mudical Examiliar mant be notified at	Be (	17. Father's Name (First, Middle, Las	t)							(First, Middle,			
aryia should ind Men marke umartic	ုင	Ralph Fowler							ıstan			tlock	
C1 10 - 01		19a. Informant's Name/Relationship		1								r Town, State, Zi	p Code)
Te, No. 1 and Heelth Am 27 ther tr		Carolyn Fowler M 20a. Method of Disposition	acrese		Place of Dispos			eve, i		X, MV	2122	cation - City or T	Cours State
Baltimore, permit. Pages 1 ar Department of Hee mportant: If tham, any injury or other anse.		1 ⊠Burial 2 ☐ Cremation 3 [		State	cemetery, cren	natory or o	other place						
nit. P artme ortan injur.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		LC									Maryland
Balt permit. Departr Import		21. Signature of Funeral Service Licensee Runeral Hone 9705 Belair Rd., Baltimore, MD 21236											23
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that c	aused the dea									Approximate
Physician		Immediate Cause (Final disease or condition	MIS		TATI	6	RR	Alni	Ti	UMER	2		Interval Between Onset and Death
/Medical		resulting in death)	a. Due to (	or as a conse			101	13 1/4	-	0 11 10 1			
Examiner		Sequentially list conditions,	b										
Sit 8d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of).										
and and II-tran	хаг	that initiated events resulting in death) Last	c. Due to (	or as a conse	quence of):								
I Records, P.O. Box 68760,  The law requires that the death certificate be executed ate has been signed by the attending physicien and begee 2 should be detached for use as the burial-transit	dical E	1			420.100 0.7.								
687 ificate g phys	edic		0										
Box eath cert	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out									23d. Date of deliv	ery
deatl	sicla	in the past 12 months?	4☐ Pregn	irth 2 ☐ Fet ant at time of		Ectopic p Other (sp						Month	Day Year
P.O. BOX 6 thet the death certific ed by the attending p detached for use as	Phys	9 ☐ Unknown	9□ Unkno										
ds, F	Completed by Physiclan/Me	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the un	derlying o	cause give	n in Part I.					he cause of death?
Vital Records, stein. The law requires the certificate has been signer rector, page 2 should be d	eted				···				_	101	/es 2[	No 3 Prol	bably 4 Tunknown
Aec le law hes t	jd H									24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
Vital Fision: The certificate rector, peg		1								1 ☐ Yes	med?	death?	2 No
of Vital Physician: this certifice ral director, p	Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		7		Otho	-		Check only o			
Of Phys or this oral dii	To	27. Manner of Death		npatient 2 [ of Injury h, Day Year)	ER/Outpatient 28b. Time of		JA	4 (14)	1	e 5 ☐ Resident		Other (Special	fy)
VISION Attending I or death. ector: After by the funer	ig.	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		h, Day Year)	Injury	м	28c. fnjury Work 1 🗆 Y	? es 2 □ N				,	
Division of or Attending Physeler death. Director: After this in by the funeral di	Certification;	3 Suicide 6 Could not be determined	288. Place	of Injury - At h	nome, farm, stre	et, factor	y, office		21	81. Location (S	Street and	d Number or Run	al Route Number,
Distance of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	Cer		bulloli	ig, etc. ( <i>Spec</i> .						City or Tov	vii, State,		
Hospital 24 hours Funeral tely filled	cai	29a. Certifying Pl	nysicien: To the miner: On the ba	best of my kn	owledge, death	occurred	at the time	e, date and	place, ar	nd due to the	cause(s)	and manner as s	stated.
Division of Vital Re To the Hospital or Attending Physicien: The within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	one) 29b. Signature and title of detilier	and mann	er stated.									
T WIT		250. Signature and title office titler	1				c. License		7 -			signed (Month,	
,		Jany Wu	wyw	0	- 02-1 7	3		20 2(	30		HTY	11 26,	2006
4		30. Name and addresslot person who PANKAS HIELE	PAL 2	or death (fte	ACK R	rint)	2 1	IECK	R	かかり	09.	BALTI	2006 MORE, mD
Sta Registr	-	31. Date filed (Month, Day, Year) APR 2 8 20	006	gistrar's Sign	ature (	ne.	,						

			ricase	Chats of Manufacial				•	
			For 1 _ State	State of Maryland			ientai Hygier	e 006	13416
			Registrar	1	Certificate of	Deam	Reg. N	lo.	10-5-10-1
	Physici	an	1. Decedent's Name (First, Middle, La:	1- wils	on.		2. Date of Death	Day the Year	3. Time of Death
	/Medic Examin		4e. Fecifity Name (If not institution, give Har 1977 Such M	e street and number)	ne 4b. City, Town.	or Location of Death	TIPSUS 3	4c. County of Death	1/2-6:
			,	7 App (10 use to	st birthday) If Under 1 Year	0000	9. Date of Birth	////	alaa (Chara a Faria
	Funeral Director		018-00-0751	ex 7. Age (In yrs. las	Yrs. Months Days		8. Date of Birth (Month, Day, Yea Oct. 16,	729 M	place (State or Foreign intry)
	land land		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d. fnside City Limits
	e filed within 72 hours after death with the Maryland at Hygiene. I dygiene. I other than "naturel", or Items 23s or 28s-f show vent, the Medical Examerer must be notilied.	ctor	Maruland NI	4 B	altimore	2			1 XYes 2 □ No
	ith the	Director	10e. Street and Number	1.	10f. Zip Code	2 1	10g. (	Citizen of What Cou	intry?
	s 23s	rai	102 N. Maa	12. Was Decedent Ever in U.S.	. 13. Was Decedent of	<i>(05</i>	N	14. Race - Amer	iece Indiae
^	fter d	Funerai	11. Marital Status 1 ★ Never Married 2 Married	Armed Forces?	If Yes, specify Cut	oan, Mexican, Puerto	Rican, etc.)	Black, White	
0036	hours after turel', or Ite	þ	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No	Specify:		Specify: B	ack
ל ה	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Decedent's Usual Occu (Give kind of work done	during most of worki	ng 16b.	Kind of Business/l	ndustry
7	filed within 72 Hygiene. ther than "nat	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	Đđ)		Prilla	te
מ	Hygid Hygid Other	Be Cc	17. Father's Name (First, Middle, Last,		mad	18. Mother's Name	(First, Middle, Maid	en Sumame)	16
<u>a</u>	d batte	To B	Samuel B	Wilson		Clotie	2 Robin	nson	Wilson
Mary	d 2 should th and Men 7 is marke treumatic		19a. Informant's Name/Relationship (	Type, Print) (Sister)	19b. Mailing Address (Stree	t and Number or Rura	Al Route Number, City	or Town, State, Zi	p Code)
o,	f Health item 27 other tr		20a. Method of Disposition	Toage 20h Plan	5 /DJ V(U) ce of Disposition (Name of	1 Dyke	Pate 20c	Location - City or T	2/206
000	0 0		1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	netery, crematory or other pla		12001	Location - City of 1	L MA
Baitimor	5 5 3		*4 Donetion 5 Dother (Specifical Strong Licer	1 1 1	22. Name and Addr	1	- 1 T	unaai	N, IVIA.
ă	Depart Import eny in		Joseph	I. Kuss	Joseph L 2222 Wil	North Av	- Balto	Home P.	216
			23a. Part 1 Enter the pisease, or com shock, or heart failure. List only	plications that caused the death. one cause on each line.	Do not enter the mode of dy	ing, such as cardiac o	or respiratory arrest,		Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition resulting in death)	a. Concer	Larynx				Onset and Death
	/Medical Examiner		( and the second	Due to (or as a conseque	ince of):				2 years
ķ		Jer	Sequentiafly list conditions, if any, leading to immediate	b. Due to (or as a conseque	ince of):				
	cuted nd ransit	Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c					
160,	le be executed ysician and le burial-transit	i Ex	resulting in death) Last	Due to (or as a conseque	ince of):				
280	eath certificate be executed attending physician and for use as the burial-transit	dicai	•	d					
ROX	certif nding use a:	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance				23d. Date of deliv	/erv
c.	at the death certifical by the attending phitached for use as the	Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown		;y		Month	Day Year
ı.	uires that the signed by discould be detacted.	Ph	Part II. Other significant conditions of	ontributing to death but not result	ing in the underlying cause gr	ven in Part I.	23e. Did tobacci	use contribute to	the cause of death?
cords,	The law requires that ate has been signed b page 2 should be deta	ed by					1 🗆 Yes	2 □ No 3 □ Pro	bably 4 DUnknown
e CO	aw re	Completed					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
r		Com					performed?	death?	2 0 No
Vital	Physician; r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			(Check only one)		
0	ding Physin. In. After this continued function	. 70	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2 E	R/Outpatient 3 DOA 8b. Time of 28c. Inju	4 W Nursing Ho	me 5 Residence		fy)
0	fte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	In _f ury Wo	ork? Yes 2 No	200. 2000.00 /1011 /11	jary oscarros	
DIVISION	Attendial of death.	Certification:	3 Suicide 6 Could not b	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office		28f. Location (Street City or Town, Sta	and Number or Rui	al Route Number,
5	nital or ars after rat Dii Hed in						·		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medicel Exar	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the to on and/or investigation, in my	ime, date and place, a opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as : nd place, and due :	stated. to the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier	mpende		3066/	29d. C	Date signed (Month)	Dey, Year) 2006
/	2 Y		30. Name and address of person who	completed cause of death (Item 2	23af (Type, Printin Balti	30661	Hd - &	11239	,
	Sta	te	31. Date filed (Month, Day, Year)	32 Pegistrar's Signatur					
×	Registr	ar	APR 2 8 2	32 Pegistrars Signatur	( Speciel				
DH	MH 17 Rev 1/2	001		and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	F				

State of Maryland / Department of Health and Mental	Hygiene	,
Certificate of Death	Pon No	~

	13	5	- 1	. 3
- 7	1.2	1 .	- 1	- 1
- 5	J	E.S	- 1	- 7
8	1	- 6	ь	- /

Weighan, Ilay	Baltimore, Maryland 21215-0036	Permit: Pages 1 and 2 should be filed within 72 hours after death with to Department of Hasilih and Martel Burniane	
	68760,	ficate be executed	physicien and

Division of Vital Records, P.O. Box

		- State Registrar						Cei	rtificate	e of L	Death			Reg. I	No.	U	10-717
¥,		1. Decedent's Nam	e (First, Middi	e, Last)									2. Date of D	eath			3. Time of Death
Physicia /Medica	_	Mary Elia	zabeth	Wei	dman								April	ス	Š,	2006	7,40 PM
Examine		4a. Facility Name (	If not institution	n, give s	street and nu	mber)			4b. City,	Town, or	Location	of Death	, , ,	- 1		y of Death	1
3-A		Baltimore	e Washi	ngt	on Med	. Cer	nter		Glen	Bur	nie				Anne	Arun	de1
Funeral		5. Social Security N	Number	6. Sex		7. Age (I	n yrs. last bii	thday)	If Under		If Under		8. Date of B	rth		9. Birthr	place (State or Foreign
Director		216-12-26	602	1 🗆	M 2⊠F		83	Yrs.	Months	Days	Hours	Min.	(Month, D Sep. 1	ay, Yea	1922	MD	ntry)
		Usual Residence o	f Decedent									i	вер. 1	0,	1/22	III	
ylan		10a. State	10b. County			10	0c. City, Tow	n or Lo	cation							1	10d. Inside City Limits
Mar	ţ	MD	Anne A	run	de1	Se	evern										1 ☐ Yes 2x No
r 28.	Se	10e. Street and Nu							10f. Zip	Code				10g. (	Citizen of	What Cour	ntry?
3a o		7810 Cypi	ress La	ndi	no Roa	d			21	144				ĪĪ	SA		
Jeath The 2	Funeral Director	11. Marital Status	ZODO EC		12. Was Dec		er in U.S.	13.			ispanic Ori	igin? (Spe	acify Yes or N		T	ce - Americ	can Indian,
r iter	필	1 Never Marr	ried 2□ Mar	ned	Armed F 1 ☐ Yes	orces? 2 <b>∐N</b> o		1	f Yes, spec	rfy Cuba	n, Mexicar	n, Puerto	Rican, etc.)		Bla	ack, White,	etc.
urs a	þ	3 Widowed			If Yes, G Year or [	ive			1 ☐ Yes 2	2 XNo	Specify:				Specia	ty: Wh:	ite
2 hou	ed		15. Deceder				16a	Dece	dent's Usua	al Occupa	ation			16b.	Kind of E	Business/In	dustry
n "n	Completed		cify only highe	st grade				(Give	kind of wor DO NOT us	rk done d se retired	during mos ')	it of work	ing				•
the end	E	Elementary/Seco	ondary (0-12)		College (	1-4or 5+)	Cr	edi	inve	stig	ator			Ba	nking	2	
Hyg othe	0	17. Father's Name	(First, Middle.	Last)							18. Mothe	er's Name	(First, Middle	a, Maid	en Suma	me)	
ld be entel ked	ToB	Milton D	. Gilbe	rt							Hele	en I	White				
mari mat	F	19a. Informant's N			oe. Print)		196	. Mailir	na Address	(Street a			I Route Numi		v or Town	State Zir	Code)
d 2 stranger		Janet C.				wh to	1		•	,							,
Heal Heal mg	1	20a. Method of Dis		SOII	/ Dau		20b. Place o	f Dispo	sition (Nan	ne of			ad, Se			<ul> <li>City or To</li> </ul>	
to to		1 🗆 Burial 2	Cremation		emoval from	State	cemete	ry, crer	natory or o	ther plac		-	28,			o., o	, and a
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, the Modical Exactical resistant be notified at once.		4 Donation	A			K	Chesap	-	-				006			sville	
Depariment of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the		21. Signature of Eu	uneral service	License	38		.01/11		. Name an							Ave. S	
70 = 4 d		poc	fee				M01411								Burn	Le, MI	D 21061
Physician /Medical Examiner		23a. Paft. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Congestive Heart Failure  Due to (or as a consequence of): Artery Disease													Approximate Interval Between Onset and Death		
executed on and rial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.															
w requires thet the death certifi been signed by the attending should be detached for use as	hysician	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 21 9 Unknown	2 monthe?	23		birth 2 (	pregnancy Fetal death		Ectopic pr Other (sp							ate of delive	ery Day Year
ent s	ру Р	Part II. Other signi	ificant conditi	ons con	tributing to d	eath but r	not resulting i	n the u	nderlying c	ause give	en in Part I	l.	23e. Did	tobacc	o use con	tribute to th	he cause of death?
n sig													1 🗆	Yes	2 🗆 No	3 🗌 Prob	oably 4 Unknown
nas e 2	Completed												24a. Wa auto per 1 🗆 Yes	s an opsy formad		Were autoprior to codeath?	opsy findings available impletion of cause of
ertific actor,	Be	25. Was case references	rred to medica			/				T .		e of Deatl	Check only	опе			
hysis his c	2	1 □ Yes 2 🗹	No	Н	lospital:	Inpatient	2 ER/O	utpatier	it 3 DC	A Othe	er: 4□Nu	ursing Ho	me 5 Res	idence	6 □Ot	her (Specif	ý)
ng P fter t	ü	27. Manner of Dea 1 Natural	ith 5 ☐ Pendi	20	28a. Date (Mor	of Injury		Time of	f 2	8c. Injun Work	at		28d. Describe	how in	jury occu	rred	
endil path. pr: A he fu	ati	2 Accident	invest	gation					М		Yes 2□	No					
rs after de	Certification:	3  Suicide 4  Homicide	6 Could detern			e of Injury ling, etc. (	- At home, fa 'Specify)	arm, str	eet, factory	r, office			28f. Location City or To			ber or Rura	al Route Number,
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	edical	29a. Certifier (Check only one)	1  Certityi 2  Medical	ng Phys Examir	ner: On the I	pasis of ex	camination ar	a, daeil nd/or in	vestigation,	at the tim , in my or	na, Jate ar pinion, dea	nd ulade, ath occurr	and dualto the ed at the time	date a	(e) and in and place,	anner at t	o the cause(s)
with Tot	Σ	29b. Signature and	title of certific	£.	W	ılı	19	17.D	290	License D 4	Number () S	5		29d. (	Date signi	25,	Day, Year) 2006
5		30. Name and add	ress of person	10000 1000	mpleted cau	se of deat	th (Item 23a)	(Type	DSP it	اله	Driv	e, 6	len B	ur	nie	MD.	21061

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 2 8 2006

37 Rigistrar's Signatura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Whitaker Shavon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Baltimore nuon If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 219.96.7209 1 ☐ M 2 🔀 F 30 Yrs. MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location * how 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If Itam 27 is marked other then "natural", or Itams 23a or 28e-f shoy ury or other traumatic svent, Ita Madical Examinar must be notified at MD Baltimore 1 Xes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 2030 USA Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cpllege (1-4or 5+) Manager ctail 12th grade Vear 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Winston Whitaker Sandra Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Whitaker/Father 2030 E. 30th Street Balto. MD 21218 Ninstan F. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or ance. Injury or Baltimore, MD Mt. Zion 4 □ Donation 5 □ Other (Specify) 21. Signatur Funeral Service Licenses 22. Name and Address of Facility
YOU JULY C. STEENE FUNEVALSEVVICES
4005 YORK ROAD BUILTMOVE MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiofulmona **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): ettending physicien for use as the buria Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ours efter death. neral Diractor: After this certificate has been sign filled in by the funeral director, page 2 should be 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 > 0 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certification: To 1 Yes/ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manny r of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral D 12 Certifying Physician: To the basis of my knowledge, death oncomed at the time, date and place, and due to the escape) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date siggled (Month, Day, Year) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Burke Widgeon 11:01PM 04 tdward 2006 /Medical 4a. Facility Name (If not institution, give street and number)

Joseph Ritchie Hospice 4c. County of Death 4b. City. Town, or Location of Death Examiner NIA Baltimore ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 217.09.8592 Hours 10**X**M 2□ F a Yrs. 06/03 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County the Medical Examiner must be notified at Baltimore Baltimore 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Avenue USA 1121 Handu 21228 230 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 1 ☐ Yes 2 No Specify: Specify: 13 ack by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Me Manyland Drydock Elementary/Secondary (0-12) Colfege (1-4or 5+) Mechanio 12th grade NIA 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any njury or other traumatic event, 0000. 17. Father's Name (First, Middle, Last) Link Sarah Widgeon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Refationship (Type, Print) 1133 Holland Road Baltimore MD 21239 Daugher tam Widgeon Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore MD 26 06 Greenmount 4 ☐ Donation 5 ☐ Other (Specify) Cremation Savices Sist Baltimore National Pille Balto. MD 21229 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia Physician /Medical Due to (or as a consequence of) Examiner prostate cancel metastatic years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 **□**/No Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director; After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DZ4176 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 N. Eutaw St Baltimore, MD

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 8 2006

Hospice

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2006 **Physician** April 12, Ruth ABRAMSON 9:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Potomac Potomac 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1918 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ F Yrs. 87 Director 579-62-7927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, If the Modical Executariant with the retillied at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 ➡No Director Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8801 Fernwood Road 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No !f Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: ģ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lena Lazarovitch Morris Selsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8801 Fernwood Road, Bethesda, MD 20817 Albert Abramson, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
King David Memorial Garden 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Falls Church, VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Pneumonia Days /Medical Due to (or as a consequence of): **Examiner** b. Coronary Artery Disease
Due to (or as a consequence of): Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed c. Organic Brain Syndrome Years Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 🔀 No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 X Natural neral Director: A filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies D 35792 April 12, 2006 Wil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #5046 50 W. Edmonston Drive, Rockville, MD 20852 Swaroop G. Rao, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2006 Registrar RELIES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (10)

			1 - For State Registrar	State of Man		artment of rtificate o			giene Reg. No.	006	134	21
	2		1. Decedent's Name (First, Middle, Last,		^	4		2. Date of De	ath		3. Time of	Death
	Physici		Bayce N	lichael	A	nders	20	Apo /	Day 10	200 G	0512	AM
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. Çity, Town	, or Location of Dea			County of Death		
	LAGIIII		Johns Huokins	Hospital		Balt	mare	City		none		
	Funeral		5. Social Security Number 6. Sec	7. Age (/	n yrs. last birthday)	If Under 1 Yea			th	9. Birth	place (State or	r Foreign
	Director		231-97-4069	^{2 F} 2 2	Yrs.	Months Day	s Hours Min	Jan 2,			intry) inia	
	פ		Usual Residence of Decedent									
	how	_	10a. State 10b. County	11	0c. City, Town or Lo	cation					10d. Inside Cit	
	Ma F-6	cto	Virginia Fairfax		Cliftor	1					1 🗍 Yes	Z No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	intry?	
	23e		12643 Water Street			2012	.4		Unit	ed Stat	es	
	- dea	Funeral	11. Marital Status	<ol> <li>Was Decedent Ever Armed Forces?</li> </ol>		Was Decedent of	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No	)-	14. Race - Amer Black, White		
98	or It	핏	Never Married 2 Married	1 ☐ Yes 2 🔼 No If Yes, Give		1□Yes 2□N	lo Specify:			Specify:		
Ö	within 72 hours after death with the Maryland ene. than "neturel", or Itema 23e or 28e-f ahow hadical Exeminer must be notillied at	d by	3 Widowed 4 Divorced	Year or Dates:						W	hite	
7	72 nat	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	ient's Usual Occ kind of work dor	e during most of wo	orking	16b. Kir	nd of Business/li	ndustry	
121	d withir giene. r then	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use reti	rea)					
7			17. Father's Name (First, Middle, Last)		IIC	ne	18 Mother's Na	me (First, Middle		one		
ä	o da b ≥	Be		anderson								
7	should be and Mental marked o umatic ava	2	19a. Informant's Name/Relationship (Ty		10h Mailie	a Addrson /Ctra	Emily et and Number or R			afson	in Corde l	
Maryland 21215-0036			James Anderson, fat				Street, C				p Code)	
di.	Health Health tem 27 other tr		20a. Method of Disposition		20b. Place of Dispo		bereet, c	Date		Cation - City or T	own State	
Baltimore,	permit. Peges 1 Department of H Important: If ite any injury or ot		1√ Burial 2 Cremation 3 √ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	cemetery, crer	natory or other p	1					
ţï	Trant P				Homewood			/2006	Pitt	sburgh,	PA	
Bal	Depermine Depe		21. Signature of Furieral Service Licens	<del>*</del> /			fress of Facility E					
	40244	N 1	Jane 1	Their			n Street,			22030	A	
			23a. Part1. Enter the disease or compleshock, or heart failure. List only or	ne cause on each line.					rrest,		Approximate Interval Betw Onset and D	reen
	Physician		Immediate Cause (Final disease or condition resulting in death)	Acute	Kespirat	ing Di	stress Sy	ndrome			1 mon	th
	/Medical Examiner		Toodking in dodain	Due to (or as a c	Respirations equence of:  Myeloge of	/	,				10	.1
		_	Sequentially list conditions,	Due to (or as a c	Myclogen	ous	Leuken	19			18 mor	iths
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of.							
	end end Il-trar	xau	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):							
8760,	death certificate be executed e attending physician end nd tor use as the burial-transit				,							
87	phys the	dlcal		1								
9 x	eath certific attending p	Physician/Me	IF FEMALE:	3c. If yes, outcome of	pregnancy					104 0-1		
Вох	atten tor u	lan	in the past 12 months?	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnar Other (specify)			2	3d. Date of deliving Month		ear
	at the de by the teched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ie oi deatii 5	J Other (specify)						
P.0	The law requires that the tee has been signed by thoage 2 should be deteche		Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	nderlying cause o	given in Part I.	23e. Did t	obacco u	se contribute to	the cause of de	ath?
ds,	sign d be	d by	Acute Rem	1 Failure	-	, ,		10	Yes 2	No 3∏Pro	bably 4 □U	nknown
Ö	w requir been s should	ete	Stroke					- H				
of Vital Records,	has has	Completed	STIVE					24a. Was auto		24b. Were aut prior to co death?	opsy findings a ompletion of ca	use of
a								1 ☐ Yes	2 <b>X</b> No	1 🗆 Yes	2□ No	
Z.	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		10	)thor	eath (Check only				
ot	Phys this al di	2	1 Yes 2 No  27. Manner of Death	1 Inpatient		3 DOW	4 🗆 Ivursing	Home 5 Resi			fy)	
	ding I h. Atter funer	6	1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) Injury	W	ork? ☐ Yes 2 ☐ No	200. Describe	now injury	Occurred		
Sic	Attending ir death. ector: Atterby the funer	cat	2 Accident investigation 3 Suicide 6 Could not be	38a Blace of Injury	At home form etc			20f Location /	Ctroot and	d Number or Rui	al Cauta Nomb	
Division	or A atter Dirac in by	Certification:	4  Homicide determined	28e. Place of Injury building, etc. (	Specify)	еет, гастогу, опто	e	City or To		)	ai Houle Ivumb	er,
_	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1⊠ Certifying Phy	sician: To the best of	ny knowlodao de-4	annurred -+ ++ ·	time data and nin-	o and due to the	021:02(=)	and manage	rtated	
	Hos 24 hc Fun stely i	edical		sician: To the best of r ner: On the basis of ex and manner stated	camination and/or in-	vestigation, in my	y opinion, death occ	urred at the time,	date and	place, and due	o the cause(s)	
	To the within of	Mec	29b. Signature and title of certifier	M		29c. Lice	nse number	Т	29d. Date	e signed (Month)	Day, Year)	
	F 3 F 8		1 /2	Mo			61814			1.1		
	3		20 Name and odding of		h (Itom 32a) /T	1	. ,			11 10,	2006	
	9		30. Name and address of person who do	in n	th (Item 23a) (Type, GOO N, Wol Signature	Lo Area	+ Balti	MUIO M	0	21287		
	Sta	to	31. Date filed (MontiAPR * 1) 4 2	32. Fagistrar's	Signature	10 01	1/	1017	·/	-1 -0 /		
	Registr		APR 14 2	006 Keen	J. J. A	soul!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:00P M ROSEMARY BUTLER 4c. County of Death 206 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ELLICOTT CITY HEALTH & REHABILITATION ELLICOTT CITY HOWARD If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🕱 F 219-12-8082 Yrs Director 88 JUNE 27,1917 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Iteme 23s or 28e-f ehow Examiner must be notified at Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 839 STAMFORD ROAD 21229 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 1 ☐ Yes 2XXNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" ir than "natura Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CREDIT ACCOUNT MANAGER RETAIL permit. Pages 1 and 2 should be filk Depertment of Health and Mental Hy important: if Item 27 is marked oth any liqury or other traumatic event ODEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JULIAN MONROE BUTLER IRENE SOPHIE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN C. BUTLER, JR./ NEPHEW 11432 OLD FREDERICK RD., MARRIOTTSVILLE, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CHESTERFIELD CEMETERY 4-18-2006 CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signator Suneral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CENEBRAL TIMOMISOSI) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown ed by the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Tyes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: A death 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P. filled in by within 24 hours efter or To the Funeral Director Completely filled in by

Baltimore, Maryland 21215-0036

Box 68760

o

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7220 ParkHeights Avenue Baltimore MD 21208 istrar's Signature 31. Date filed (Month,

State Registrar

Medical

29b. Signature and title of certified

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Physic /Medi Exami

**Funeral** Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

iual Residence of Decedent a. State 10b. County 10c. City, Town	4b. City, To		eath	Day Year  1 2 6 6 7 9 8 1 1 1 8 7 2 4 9 8 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	co					
Fecility Name (If not institution, give street and number)  NUMBULA AMOUND MANUAL CON;  Social Security Number 6. Sex 7. Age (In yrs. last bin 202–18–5578 1 M M F 81  sual Residence of Decedent a. State 10b. County 10c. City, Town	4b. City, To	SW/566 Year If Under 24	eath	4c. County of Deat	th thplace (State or Foreign burity)					
Social Security Number  202-18-5578  1 M 25 F 81  202-18-5578  1 M 25 F 81  10c. City, Town	Yrs. Months [		Hrs. 8. Date of Birth	11/8/24 9. Bird	thplace (State or Forei					
Social Security Number  202-18-5578  1 M 25 F 81  202-18-5578  1 M 25 F 81  10c. City, Town	Yrs. Months [		Hrs. 8. Date of Birth	11/8/24 9. Bin Mar	thplace (State or Forei					
iual Residence of Decedent a. State 10b. County 10c. City, Town	Yrs.	Jays Hours	1179/19	Mar Mar	Tyland					
a. State 10b. County 10c. City, Town	m or Location				.y taria					
	m or Location				10d. Inside City Lim					
aryland Somerset Pri	incess Anr				1 <b>X</b> Yes 2 □					
Maryland Somerset Princess Anne  10e. Street and Number 10f. Zip Code 10g. Citizen of Wha										
	10f. Zip C		11	_	ountry?					
11974 Edgehill Terrace	140 114 10 114	21853	2 (54 - V 1)	USA	rices Indias					
Armed Forces?	If Yes, specify	Cuban, Mexican, P	uerto Rican, etc.)							
If Yes, Give	No Specify: White									
	. Decedent's Usual (	Occupation		16b. Kind of Business	/Industry					
(Specify only highest grade completed)	(Give kind of work	done durina most of	working							
	Seamstress	5		Shirt Manu	ıfacturing					
. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, M	Maiden Sumame)						
Edward W. Marshall		Dorot	tha Linton							
	•				Zip Code)					
Betty Jacobs/daughter	ll Westmir	nster Dr.,	Berlin, M	ID 51811						
cometes	of Disposition (Name ary, crematory or other	er place)		20c. Location - City or	Town, State					
4 Donation 5 Other (Specify)	oury Crema	atory $4/$	17/06	Salisbury	, MD					
Signature of Funeral Service Ligensee	22 Name and	Address of Facility	al Home Pro	fessional	Associati					
Kell R Sleiney CFSP	501 Sr	now Hill H	kd., Salisk	oury, MD 21	.804					
3a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode	of dying, such as car	rdiac or respiratory arre	est,	Approximate Interval Between					
	endo mah	managed 1	colitio		Onset and Death					
Sequentially list conditions.  Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  # SCV ()  Due to (or as a consequence of):										
at initiated events C.		()			5 years					
Due to (or as a consequence	or):									
d										
FEMALE:										
in the past 12 months?	h 3⊟Ectopic preg	gnancy		23d. Date of de Month	Day Year					
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time or death	5 ☐ Other (spec	city)								
	in the underlying car	ise given in Part I	23e. Did tot	bacco use contribute t	o the cause of death?					
III. Calai digimicani concinci continuani gi ci dodini ci ci continua	and only g out	Joe given in van v								
			autops	sy prior to	utopsy findings availa completion of cause					
			1 □ Yes	2 No 1 ☐ Yes	s 2 No					
5. Was case referred to medical examiner?	,	Othor								
1 Tes 20 No 1 Inpatient 2 EH/OL		4   Nuisi			ecify)					
1 Natural 5 Pending (Month, Day Year)				w injury occurred						
2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				troot and Number of E	Pural Route Number					
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide   Accident determined   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28c. Injury at Work?   28c. Injury at Work?   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c. Injury at   28c.										
			place, and due to the c	ause(s) and manner a	s stated					
	an death convered of	the time date and r		auso(s) and mainer a	3 Stated.					
9a. Certifier  (Check only  2 ■ Medical Examiner: On the basis of examination ar				late and place, and du	e to the cause(s)					
9a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge	nd/or investigation, i		occurred at the time, d	late and place, and du 29d. Date signed (Mon						
9a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.  9b. Signature and title of certifier	nd/or investigation, i	n my opinion, death	occurred at the time, d	29d. Date signed (Mon	oth, Day, Year)					
9a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.  9b. Signature and title of certifier	nd/or investigation, i	n my opinion, death	occurred at the time, d	29d. Date signed (Mon						
9a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.  9b. Signature and title of certifier	nd/or investigation, i	n my opinion, death	occurred at the time, d	29d. Date signed (Mon	nth, Day, Year)					
1 1 3 missan	Never Married 2   Married   1   Yes 2   No   If Yes, Give   Year or Dates:	Swidowed 4   Divorced   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   No   Year or Dates:   1   Yes 2   Year or Dates:   1   Yes 2   Year or Dates:   1   Yes 2   Year or Dates:   1   Yes 2   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1   Year or Dates:   1	Tyes 2 No Specify:   Tyes 3 No Specify:   Tyes 3 No Specify:   Tyes 3 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 4 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 5 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7 No Specify:   Tyes 7	Amad Forces   Amade   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Company   Co	Topic   Married   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   C					

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F		Mental Hy	giene		13424
	Discolati		1. Decedent's Name (First, Middle,	Last)				2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		Jasper S. Baker	r					12, 200	06	7:28am ^M
	Examin		4a. Facility Name (If not institution, g	give street and number	)	4b. City, Town, o	r Location of Dea			y of Death	
			Wilson Health	Care Center		Gaither			Mont	gome	
	Funeral			. Sex 7. A	ge (In yrs. last birthday	If Under 1 Year  Months Days	If Under 24 Hrs Hours Min		rth ay, Yea <i>r)</i>	9. Birth	olace (State or Foreign ntry)
L	Director		061-09-4450 Usual Residence of Decedent	Hall ZU	96 Yrs.			Dec. 2	3 1909	Eng1	
	and and		10a. State 10b. County		10c. City, Town or L	ocation				T.	10d. Inside City Limits
	Manyl f sho	ō	Manual and Manual and		Caithona	h					1⊠Yes 2∐No
	the 28e	Directo	Maryland   Montgor	пегу	Gaithers	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	3a or		301 Russell Avenu	10 #302		20877			United		•
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of F	lispanic Origin? (	Specify Yes or No			can Indian,
ထ	after or Ite	Ψ	1 ☐ Never Married 2 ☐ Married	Armed Forces		If Yes, specify Cubi		rto Rican, etc.)		ick, White,	etc.
ğ	rel', c	i by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specia	^{fy:} Whi	te
2-0	filed within 72 hours atter death with the Maryland Hygiene. other than "neturel", or Items 23a or 28e-f show ent, It a Madical Evertiner matte rediffed at	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occup kind of work done	during most of wo	orkina	16b. Kind of B	Business/In	dustry
2	Athin ne.	ldu	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	d)				
2	led w lygier her ti	Ŝ	12 17. Father's Name (First, Middle, La	ant)	Assi	stant Vic		lent Ime (First, Middle	United		nds
anc	d tal	Be							, машен зита	me)	
چ	d Mer nark	⁶	Robert Sancroft  19a. Informant's Name/Relationship		40h 14-10	Add (Ctt	Phyllis			0 . 7	0:11
Ma	d 2 sl th and 7 is r treur					ng Address (Street					· ·
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic once.		Brenda S. Baker  20a. Method of Disposition	(Daughter)		1 Bradbur		Date	20c. Location		
ğ	Pages nent of l ont: If its ury or o		1 ☐ Burial 2 🖾 Cremation 3				1			•	
를	permit. Pag Department Importent: I any injury c		<ul> <li>4 □ Donation 5 □ Other (Spe</li> <li>21. Signature of Funeral Service Lid</li> </ul>	-	Metropol	itan Crem 2. Name and Addre					, Virginia
Ba	permit. Departr Importe any inje	J ]	1 DA 91	(1)11	41	O East De	er Park	Drive	inerar i	TOILE	
		-	23a. Part J. Enter the disease, or co	omplications that cause		aithersbu ter the mode of dvir			rrest		Approximate
		95 1	shook, or heart failure. List or Immediat Cause (Final	ily one cause on each i	ine.		3, 000, 00		,,,,		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	_ 0	ailure to	Thrive					
В	Examiner		1		a consequence of):		1044				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Recent	Crebrovasc	ulai Acci	dent				
	uted d ansit	Examiner	Cause (Disease or injury that initiated events								
o,	exec an an rial-tr		resulting in death) Last	Due to (or as	a consequence of):						
8760	cate be executed chysician and the burial-transit	dical		đ							
9	certifica nding ph use as th		IE EEMAN E.								
Вох	leath certifica attending ph I for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1⊟Live birth		Ectopic pregnancy	/			te of delive	,
о. Е	0 0 0	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant a 9☐Unknown		Other (specify)			M	onth	Day Year
<u>Ч</u>	that the de ed by the detached	Phy	9 Unknown					00 Did			
Ś	gn gn	by	Part II. Other significant conditions Diabetes II, Chi		_		en in Paπ I.				he cause of death?
ord	w requir been si should	ted							Yes 2 No	3   Proc	pably 4 Unknown
Vital Records,	> 0 0	Completed	Prostate Carcino	oma, Hypert	ension, Re	nal Insuf	ficiency	i auto	psy	prior to co	psy findings available mpletion of cause of
H	: The lav	Cor	Anemic Chronic I	)isease				1 Tes		death? 1 ☐ Yes	2 <b>X</b> No
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Manitali		211		ath (Check only			
-	sir dij	^L	1 ☐ Yes 2 ☒ No		ent 2 ER/Outpatie		- Mindraling i	Home 5 ☐ Resi			ý)
<u></u>	ling F	lon:	27. Manner of Death 1  Natural 5 □ Pending	28a. Date of Inj. (Month, Da	ay Year) 28b. Time of Injury	Wor	k?	28d. Describe	how injury occur	red	
S	ttend death stor: , the f	icat	2 Accident investigat 3 Suicide 6 Could not	he	ium. At home from at		Yes 2 ☐ No	20f Location /	Ctroot and Numi	har as Our	al Route Number.
Division of	or A after a Direction by	Certification:	4 ☐ Homicide determine	building, e	jury - At home, farm, st tc. <i>(Specify)</i>	reet, ractory, office		City or To		per or mura	ir Houle Number,
_	purs a		29a. Certifier 1X Certifying	Physician: To the best	of my knowledge deat	h occurred at the tic	ne date and place	a and due to the	cause/s) and m	annor as s	tated
	24 h 24 h e Fur etely	edical		aminer: On the basis of and manner si	of examination and/or in	vestigation, in my o	pinion, death occi	urred at the time,	date and place,	and due to	the cause(s)
	To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	Me	29b. Signature and title of certifier		/-	29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	->-0		H. R. her	t-Din	ale - 10	Ø D041	15	4	April	12,	2006
	20		30. Name and address of person wh				1.7		1		
	20		H. Robert Birso	•	1	*	ue, Gait	hersburg	g, MD 20	878	
	Sta	te	31. Date filed (Month Pay Year) APR 1 3	32 Rahist	rar's Signature						
	Registr	ar	MLK T 3	2006	was St Ag	gover)					

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 10, 2006 ear **Physician** Mary S. Bright 8:50 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dunkirk
If Under 1 Year If Under 24 Hrs. 11407 Baumann Court Calvert County 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 💢 F Yrs Director 579-58-0193 April 1, 1945 Washington, DC 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ahow the Medical Examiner must be notified at Director 1 Yes 2 No Calvert County Dunkirk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or Itema 23e or 11407 Baumann Court U.S.A. 20754 deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify þ Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other then College (1-4or 5+) Budget & Systems Analyst Federal Government permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Itam 27 Is marked other any injury or other traumatic avant, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence D. Smith Kathryn E. O'Neil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11407 Baumann Court, Dunkirk, Maryland 20754 Patrick J. Bright (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aprilat18. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 2006 Clinton, Maryland 21. Signature of the party solice Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Michael W. Lee 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** MA SIMONI /Medical Examiner S— uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires thet the death certificate be executed use es the burial-transit and Due to (or as a consequence of) Box 68760. ettending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown ģ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I cete hes been signed by the pege 2 should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; certificete 2 XNO 1 Tyes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2000 2 1 🗌 Yes 2 ER/Outpatient Residence 6 Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending s after death. 1 TYes 2 TNo investigation the the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) δ filled in Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel To tha I 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier 29c, License number April 11, 2006 3d. Name and address of person lD 31. Date filed (Month, Day Year) 32. Registr s Signature State 2005▶ Registrar

State of Maryland / Department of Health and Mental Hygiene 🖺 🧎 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day Year Carol Putman Benton April 10 2006 8:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day) 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1942 Months 1□ M XXF 215-42-3225 63 Dec. Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location worle! 10d. Inside City Limits r then "nature!", or items 23a or 28a-f ehov the Medical Examiner must be notified at Frederick Maryland Frederick 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 606 Lee Place U.S.A. death , Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No 1 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Supervisor **Electronics** 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: if Item 27 is marked othen any loury or other traumatic event aggre. 18. Mother's Name (First, Middle, Maiden Sumame) Be Lester William Putman Viola Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Benton, Sr., husband 606 Lee Place, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens April 13, 2006 Frederick, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Keeney and Basford PA Funeral Home GND MO0255 106 East Church St., Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) OUARUAN **Physician** Months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and al-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed physician at s the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical as the attending I IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant al time of death 5 Other (specify) ☐ Yes 2 ☑ No P.O. 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 12ena 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case reterred to medical examiner? Heart 2. No Division of Vital 1 Yes Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 - Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26609 HM/ (2, 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Joseph Ashwal, M.D., 56 Thomas Johnson Drive, Frederick, MD 21702 31. Date filed (Month Prov. Year) 2 2006 32. registrar's Signature State gistrais signicia. Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:50рм 12, Peyton Ε. Bradley April 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Federalsburg 6548 Eldorado Road 8. Date of Birth (Month, Day, Year) Aug. 29, 1940 Maryland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1X□M 2□F 65 Yrs. 214-36-6004 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County ir than "natural", or Itame 23s or 28s-f show 1 ☐ Yes 2 X No MD Dorchester Federalsburg Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6548 Eldorado Road 21632 United States by Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Dressier Industries al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Maintenance Gas Pumps & Tools 12 .. Peges 1 and 2 should be filed v Iment of Health and Mental Hygie rant: If Item 27 is marked other t jury or other traumatic event, IL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy T. Ford Emmerson F. Bradley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gerry E. Bradley/Spouse 6548 Eldorado Rd., Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mid-Shore Cremation 04/13/06 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service License 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GLIDBLASTOMA MULTIFORME MONTHS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physicien and use as the burial-transit or Attanding Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes been si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has t irector, page 2 s autopsy 1 ☐ Yes 1 Yes 2√ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and the of certific 29d. Date signed (Month, Day, Year) ATTENDING 30. Tame and address of person who completed cause of death (Item 23a) (Type, Print) 321 Bloomingdale Ave., Federalsburg, MD 21632 Pau1 Reinbold, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra (marty)

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Amend Item	State of M	larylan erb.,	d / Depa , G854 (	artmer rtifica	t of H <b>706a</b> 1	ealth a hb Death	and M	lental H	ygien Reg. N	e () ()	6	13429
			1. Decedent's Name (First, Middle, Las								2. Date of D	eath	ay	Year	3. Time of Death
	Physici /Medio		Izora Bell Bivens	;							April	. 13	200		11:00 A.M
	Examir		4a. Facility Name (If not institution, give	street and number	)		4b. City	, Town, or	Location of	of Death	-	4	c. County	of Death	
			15036 Weller Road		(1	for a felicity of the	Har	ncock or 1 Year	If Under	24 Hrs	O Data of F	let	Wash		
П	Funeral		5. Social Security Number 6. Social Security Number 1	x □M 2 <b>X</b> 0F		1ast birthday) 78 Yrs.	Months		Hours	Min.	8. Date of B (Month, I June 1	Day, Yea	327	9. Birthp Cour MD	lace (State or Foreign stry)
	Director		218-50-2713 Usual Residence of Decedent			/0					Julie 1	, 1	121	עויו	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					_		10d. Inside City Limits	
	a-f et	ctor	MD Washingt	on	На	ancock									1 ☐ Yes 2√ No
	or 28	Director	10e. Street and Number				10f. Zi	p Code				10g. 0	itizen of V	Vhat Cour	ntry?
	ath w	rail	15036 Weller Road					L750					USA		
	er de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	2	l.S. 13.	Was Dece If Yes, spe	dent of Hi orify Cuba	ispanic Ori n, Mexican	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	10-		k, White,	en Indian, etc.
36	hours after death with the Maryland tural', or Itema 23e or 28a-f show al Examinational be mortified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	_		1 🗆 Yes	2 XN0	Specify:				Specify	. Wh:	ite
Ö	s within 72 hours after death with the Marylan liene. I then "naturel", or itema 23e or 28a-1 show Ite Mudical Examene must be notified at		15. Decedent's Ed	ucation		16a. Dece				A - 6 d		16b.	Kind of Bu	siness/Inc	dustry
215	within 7. ene. then "n	Completed	(Specify only highest gra	de completea)  College (1-4or	5+)	life.	DO NOT	ise retired	during mos	t of work	ing				
7		Con	10			Bake:	<u>r</u>						estau		
Ind	e ta b	Be	17. Father's Name (First, Middle, Last)								e (First, Midd		n Sumam	Θ)	
Z	should nd Men marke umaric	မ	Will Shoemaker			105 14-15		- (C			e Welle		as Taura	Ctata Zia	Codel
Maryland 21215-0036	C		19a. Informant's Name/Relationship (1				al 5300				al Route Num	-0.00			Code)
	leal leal ther		Carl E. Bivens/Sor	1	20b. F	Place of Dispo	sition (Na	me of		rcei	sburg,	20c.	Location -	City or To	own, Slate
nor	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		∌	cemetery, crei one Bri				0/. /	21 /06	Цот	ncock	MD	
Baltimore,			21 agrature of Puneral Service Licen		100				ss of Facilit				st Ma		+1000 t
Ba	Departr Imports any inji		) K. ( )	TOA	)	Gr	ove I	Juner	al Ho	me I				_	750 <b>-</b> 0368
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause	d the deat	th. Do not ent	ter the mo	de of dying	g, such as	cardiac	or respiratory	arrest,	<del></del>		Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition	i		NCLUI	n ,								Onset and Death
	/Medical		resulting in death)	Due to (or a			V								
П	Examiner		Sequentially list conditions	b. CCRON Due to (or a	ARY	ARTE	RY	DI	SEA	SE					
	pe jis	Examine	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							00	alle ve ki				
	xecut and II-tran	хап	that initiated events resulting in death) Last	c. Joue to (or a	s a conseq	quence of):	11-0	100	4.90	PA	IHY			-+	
8760,	The law requires that the death certificate ba executed the base been signed by the attending physician and page 2 should be detached for use as the burial-transit					1C						111	TAT	TON	
687	ficate p phys	Physician/Medical		d	VER			V/1 C							
Box	eath certific attending pl for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			75						23d. Dat	e of delive	ary
	death e atte	icia	in the past 12 months? t ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown			Other (s	pecify)					Mor	nth	Day Year
P.0	at the de by the	hys	9 ☐ Unknown	9LJ Unknown											
	res that igned to be det	by	Part II. Other significant conditions c	ontributing to death	but not res	sulting in the u	inderlying	cause give	en in Part I						ne cause of death?
Records,	v require been sig	ted									16	Yes	2 <b>12</b> No	3   Prob	ably 4 □Unknown
ec	e law I has b	Completed										is an opsy formed?		Vere auto prior to con leath?	psy findings available mpletion of cause of
E =		Co									1 ☐ Yes			Yes	2□ No
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1		Othe Othe	00		h (Check only				
of	Phya rthis ral din	5 To	1 Yes 2 No	1 🗀 Inpai		28b. Time o		OA 28c. Injury Work	4 🗆 NU	ursing Ho	ome 5 Re 28d. Describ				y)
O	ding F th. : After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	М		k? Yes 2□	No			,		
Division	r Attending er death. rector: Afler by the fune	ifica	3 Suicide 6 Could not be 4 Homicide	289. Place of II	njury - At h	ome, farm, str	reet, facto	ry, office			28f. Location City or T	(Street	and Numb	er or Rura	l Route Number,
Ö	s afte at Dire	Certification;	4   Hornicide	building, e	etc. (Specif	<i>iy)</i>					City Of 1	OWII, Sie	10)		
	To the Hospital or Atten within 24 hours after deal To the Eunaral Director: completely filled in by the		(Check only 2 Medical Exam	ysician: To the bes	of examina										
	To the P within 2. To the F complete	Medical	one) 29b. Signature and title of certifier	and manners	stated.	. ,	29	c. License	a number			29d. [	ate signed	d (Month.	Day, Year)
	₹.₹.8		Danna 1		M	n	-	DIV	V=1	105	RE	A			0,2006
•	1		30. Name and address of person who	completed cause of	death (Iter	m 23a) (Type	Print)			14					
	6		ANITA NATIAR,			HILL		NUE	= (	HA	CERS	5 70	CON	LI	21742
	Sta	ate	31. Date filed (Month, Day, Year)	7	trar's Signa									,	
	Regist	rar	APR 2 7 2006	Floures	15 A	CASSAGL									

1	1		for AMEND#9 4/17/06 pe	State of Marylan	d / Depa	artment	of Health a	ind Me	ental Hygi	ene	131.	311
			Registrar AACO Health Dep	t CMH	Cei	rtificate	of Death		Re	g. No.	109	J ()
	Physicia	an	1. Decedent's Name (First, Middle, Last)	•					2. Date of Death  Month  April 1 10	Day 2006 Year	3. Time of 4:50	Death AM
	/Medic Examin		Anthony Cioffi, Jr 4a. Facility Name (If not institution, give si		-	4h City T	own, or Location of		April I(	4c. County of Deal	1	
	Examin	eı	Charlestown Nursin	ŕ			nsville	Dogui		Baltimore		
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.	last birthday)	If Under 1		Min	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or	Foreign
	Director		377 10 0104	M 2□F 90	Yrs.	W.Gritano	Suy Tiouis		02/20/19	)16 <del>Pen</del>	<del>nsylvan</del> :	<del>ia</del>
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				New	Jersey 10d. Inside Cit	y Limits
	Mary	tor	Maryland Baltimore	Cat	onsvil	le					XXYes	2 🗆 No
	or 28	Director	10e. Street and Number			10f. Zip (	Code		10	g. Citizen of What Co	untry?	
	ath w	ral	715 Maiden Choice	APT.CC518		212	228		Ţ	JSA		
	items items	Funeral		<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1XXYes 2 □ No</li> </ol>	.S. 13. \	Was Decede f Yes, specif	ent of Hispanic Orig fy Cuban, Mexican,	in? (Spec , Puerto R	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit		
990	urs aff	by	1 ☐ Never Married 2 ☐ Married  3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WWI	т	1□Yes 2	XNo Specify:			Specify: Wh	ite	
9	filed within 72 hours after death with the Maryland Hygiene. ither then "naturel", or items 23a or 28a-f ehow ent, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual	Occupation	of working	1	6b. Kind of Business/		
2	within ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use	k done during most e retired)	OF WORKING		Jnited Sta	tes	
2	iled w tygier ther ti		12 17. Father's Name (First, Middle, Last)		Audit	or	19 Mothes	da Nome		reasury		
and	d be f	o Be	Anthony Cioffi, Si	·					Mary Ros	aiden Sumame)		
Maryland 21215-0036	shoul nd Me mari umati	<b>T</b>	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (				City or Town, State, 2	Zip Code)	
	and 2 elth a 27 le		Charles Anthony Co	ioffi/ Son						e, PA 1722		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-1 ehow ery injury or other traumatic event, the Medical Examiner must be notified at ODGS.		20a. Method of Disposition	20b. F	Place of Dispo emetery, crem Mary 1	sition (Name	e of her place)	Da	ite 2	0c. Location - City or	Town, State	
Ē	Pag tment tent:		4 □Donation 5 □ Other (Specify)	Ve	terans	Cemet	tery 0			Crownsvill		
Ba	Departimon important in portant i		21. Signature of Funeral Service License	Э	1					Evans Fune MD 20715	ral Home	e
			23a. Part1. Enter the disease, or complic	ations that caused the deat							Approximate	
	Pnysician		Immediate Cause (Final	e cause on each line.	12		iver de				Interval Betw Onset and D	reen
	/Medical		disease or condition resulting in death)	Due to (or as a conseq			con Ca	nea	Le			
	Examiner		Sequentially list conditions, b.									
	ed sit	line	tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of).							
	xecut end	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	<del></del>						
8760,	ate be executed hysicien end the burial-transit	cai E	d									
	rtificat ng ph)		IE EENAN E.									
Box 6	leath certific attending pl	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 Live birth 2 Feta	Ideath 3	Ectopic pre				23d. Date of del	,	
P.O.	the at the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐ Unknown	eath 5□	Other (spe	cify)			Month	Day Y	ear
	The law requires thet the death certificate has been signed by the attending plage 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	nderlying car	use given in Part I.		23e. Did toba	acco use contribute to	the cause of de	eath?
Records,	quires n sign ald be		Stron	he					1 ☐ Yes	s 2⊟No 3□Pr	obably 4 🗆 Ui	nknown
000	aw require s been sig 2 should b	Completed							24a. Was an	24b. Were au	topsy findings a	vailable
<u>~</u>	The law ste has page 2 s	mo						_	autopsy perform 1 Yes 2	ed? prior to death?	completion of ca 2 □ No	use of
/ita	Physician: rthis certifice ral director, p	Be (	25. Was case referred to medical examiner?				26. Place	of Death	Check only one			
<del>_</del>	Physi this o	5	1 ☐ Yes 2 ☐ No Ho		ER/Outpatien					nce 6 □Other (Spe	cify)	
O	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Dale of Injury (Month, Day Year)	28b. Time of Injury	M 28	c. Injury al Work? 1 ☐ Yes 2 ☐ N	- 1	d. Describe hov	v injury occurred		
Division of Vital	Attending in death.  ctor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - Al ho	ome, farm, str					eet and Number or Ru	ral Route Numb	Θr,
Ó	tal or	Certification:	4  Homicide determined	building, etc. (Specif	y)				City or Town,	State)		
	To the Hospital or Attending Physician: The within 24 hours efter death.  To the Funaral Director: After this certificete he completely filled in by the funeral director, page	edical	(Check only 2 Medical Examin	cian: To the best of my knows: On the basis of examina	whedge, death	Consumed as	Uthe time, date and	place, a	id due to the car	use(s) and mariner as	tital ad.	
	To the within 2. To the I complet	Med	one)  29b. Signature and title of certifier	and manner stated.		т	License number			d. Date signed (Monti		
)	8 4 8 4		) \\ \f	Jan 1	110			00			CL	
			30. Name; and address of person who con	npleted cause of death (Item	1 23a) (Tvoe	Printi 🔑	2020				177	. 00
			1 Eram	ans, 7(1	MC	eill	u Chi	one	Ca	ue (d	lones	MEA
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 20	32. egistrar's Signa	iture	and of				,	7/7	20
	9,011			- Two	-	1					416	4//

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:13 AN nes av 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner izabeth ursing IMGY City Lenter al 7. Age In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 88 Yrs. 1 □ M 21 F Director 213-40-2416 November 25,1917 North Carolina Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show pe mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

In procinit: If item 27 Is marked other than "natural", or Items 23a or 28e-f show fam injury or other treumatic event, the Madical Examinat must be indifficed an one. 1 ☐ Yes 2X No Director MD Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4925 Western Pike 21750 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. shire if item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed by 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) County Government Efementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Browne Mary Alice Welch 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert A. Cohill/Son 1913 Westchester Ave. Catonsville. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St.Peter's Catholic 04/12/06 Hancock, MD 21. S nature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician men ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a cons Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed oidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 10 page 2 s certificate has autopsy performed Histor 1 ☐ Yes 2 ☐ No pneumonia 2 No 0 the Hospital or Attending Physician: director, Be 25. Was case referred examiner? to medical 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and mainer. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cass of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filled (Month, Day, Year)

APR 2

2006

**ORIGINAL** 

MSON

32 Règistrar's Signature

								nd Mental H	ygiene	2006	13432	
		<b>j</b> .	1. Decedent's Name (First, Middle, Last)	G855_5/1	10/06ei	fificate of	Death	100	Reg. No	.000	10406	
8	Physici		George Paul Curtis,	Sr.				2. Date of I	Da			
	/Media		4a. Facility Name (If not institution, give street and no			4b. City, Town,	or Location of	Apri.	-	4 200 . County of De		
			St. Mary's Nursing Cen	ter		Leonar	rdtown			St. Mary's		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F	7. Age (In yrs. la 87	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Birth Day, Year)	9. B	irthplace (State or Foreign Country)	
	A. A.		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation						
	-f aho	to	North Carolina Harnett	,	Sanfo						10d. fnside City Limits 1 Yes 2000	
-	or 28e	irec	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What (		
	23a	raiD	111 Timberline Drive			2733	32			USA		
036	perim. Tages I and a should be little within 72 hours after beath with the maryland popular. Tages I and Mental Hygiene. Important: if flem 27 is marked other than "natural", or items 23s or 28e-f show any injury or other treumatic avent, the Madical Examiner must be notified at 90ce.	by Funeral Director	Armed F	2 □ No ive	I	Vas Decedent of I Yes, specify Cub ☐ Yes 2 🗓 No		n? (Specify Yes or f Puerto Rican, etc.)	No-	14. Race - American Indian, Black, White, etc.  Specify: Black		
21215-0036	natura	Completed	15. Decedent's Education (Specify only highest grade completed,			ent's Usuaf Occup kind of work done		of warding	16b. K	ind of Busines	s/Industry	
12	han.	mpi	Elementary/Secondary (0-12) College	1-4or 5+)	life. L	OO NOT use retire	d)	n working		_		
9	Hygie Sther I		17. Father's Name (First, Middle, Last)		гаг	mer	18 Mother's	s Name (First, Midd		oacco F	armer	
Maryland	Aental Aental Treed of	To Be	Marty Curtis					tie Thoma		our ane,		
ary	and N		19a. Informant's Name/Refationship (Type, Print)		19b. Mailin	g Address (Street	and Number	or Rural Route Num	ber, City o	or Town, State,	Zip Code)	
<u>ა</u>	fealth m 27 har tr		Margie Buie/ Daughter				ne Driv	e, Sanfor				
altimore,	if its		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from	State Cer	metery, crem	sition (Name of natory or other pla	- Λ	Date pril 21,	_	ocation - City o		
ıtı E	artme ortant Injury		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	Char		Orial Gard	CIIS	2006		rdtown,	Maryland ————————	
ä			michael Nara Han	lener &	Ma P.	ttingley-G D. Box 270	ardiner Leonar	Funeral Hom dtown, MD 2	e, P.A 0650	•		
	*		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused to death.	Do not ente	er the mode of dyin	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between	
	hysician		fmmediate Cause (Final disease or condition resulting in death)		are	inor	nato	xus)			Onset and Death	
-	/Medical xaminer		Due to	(or as a conseque	nce of):	7-00	Va.	420	7		1010	
ξė.	新年 <b>美</b> 参与党	er	Sequentially list conditions, if any, leading to immediate Due to	(or as a conseque	ence of):	ale (	ian				year,	
patro	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.								O	
58760,	physicien and sthe burial-transit		resulting in death) Last Due to	(or as a conseque	ence of):							
	physic	dical	d									
Box	attending p	n/Me		tcome of pregnan						23d. Date of de	Nincon	
ecords, P.O. Box (	by the atte	Physician/M	in the past 12 months?	ointh 2 ∏ Fetal on nant at time of dea own		Ectopic pregnancy Other (specify)	<i>'</i>			Month	Day Year	
g. §	igned by be detac	Ph	Part II. Dther significant conditions contributing to d	eath but not result	ting in the un	derlying cause giv	en in Part I	23e Did	tobaccou	se contribute t	to the cause of death?	
Records,	n sign	d by				ao., y mg caaso giv	or arr arri.		Yes 2		robably 4 Unknown	
0 3	s been si	Completed						24a. Wa	s an	24b. Were a	utopsy findings available	
Ĭ g	ate h	EoC						per	opsy formed? 2 No	prior to death?	completion of cause of	
/ <b>Ita</b>	ector, p	Be (	25. Was case referred to medical examiner?					Death (Check only		10.16	5 2 110	
of Vita	al dir		1 ☐ Yes 2 € No Hospital: 1 ☐ 27. Manner of Death 28a. Date		R/Outpatient		4 PIAUISI	ng Home 5 ☐ Res			ecify)	
9 9	Afte	tion		th, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 ⊡No	28d. Describe	how injur	y occurred		
DIVISION OF VITAL	ar death.	Certification:	3 Suicide 6 Could not be	of Injury - At hom	ne, farm, stre			28f. Location	(Street and	d Number or R	lural Route Number,	
בֿ בֿ	rs aft		Build	ing, etc. (Specify)				City or To	own, State,	)		
HOM	within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the band man	asis of examination	ledge, death on and/or invi	occurred at the tirestigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time	cause(s)	and manner a	s stated. e to the cause(s)	
Tothe	o tha	Mec	29b. Signature and title of certifier	ner stated.		29c. Licens				e signed (Mon		
•	> - 0		) lamar	arlos	=A11	J.D	064	19		-17-0		
				se of death (Item 2			~ C	•		,		
	49		James P. Jarboe, M.D. 31. Date filed (Month, Dat. Year)	300		otch Roa	d Holly	ywood MD :	20636			
6.	Sta Registr	-	APR 1 7 20067	er trar's Signatu	1	green .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Labe Na 1006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death **Examiner** MIRE HOSD: 124 Clmari tan mon If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 🐉 □ F 93 Director 22,1913 215-24-4804 Jan. Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other than "natural," or items 23a or 28a-f show traumatic event, the Medical Espanical regard to notified at 1 Yes 2 □ No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 6808 Collinsdale Road 21234 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if I lem 27 is marked othe any injury or other traumatic event, once 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Scriber Nettie Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara E. Barber / Daughter 6808 Collinsdale Road Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery April 21,06 Hollywood, Maryland 21. Signature of Fungral Sc Edward N. B 22. Name and Address of Facility Brinsfield Funeral Home PA. Brinsfield Jr. M00052 22955 Hollywood Road Leonardtown, MD 20650 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5,5 Physician day disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-translt The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medicai the t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown þ Year Month Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 No 20 No Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 🗀 Yes 2 No after death filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d, Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number т 23а) (Туре, se of death (Ite 32. Registrar's Signature 31. Date filed (Month, Day, Year, State APR 1 8 2006 Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Maryland /	-	artment <i>tificate</i>			ind Me		iene g. No.	06	134	34
			1. Decedent's Name (First, Middle, Last)							2. Date of Deat Month	h Day	Year	3. Time of	Death
	Physicia /Medic		JOY SAROJA DR	UMHELLER						April	07	2006	5:10	РМ
è	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location o	f Death		4c. Co	unty of Death		
			Washington Adver					Park				ntgome	-	
	Funeral Director		5. Social Security Number 6. Sec 1578.02.9738	7. Age (In yrs. last i	Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, August	^{Year)} 31,19	9. Birthp Cour 78 Vir	lace (State on htry) ginia	r Foreign
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c, City, To	own or Lo	cation						1	0d. Inside Ci	ty Limits
	aho aho	5				Sprin	C						1 <u>▼</u> Yes	1
	28a-f	Directo	Maryland Montgome  10e. Street and Number	Ly DII	VCL	10f. Zip				1	0g. Citizen	of What Cour	ntry?	
	with a or	<u></u>	1853 Featherwood S	Street			904				U.S.		, .	
	oath	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. \	Was Deced	ent of Hi	spanic Orig	gin? (Spec	cify Yes or No-		Race - Americ	an Indian,	
	r Item	Funerai	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No	1	t Yes, spec	erry Cubai	n, Mexican	, Puerto F	Rican, etc.)	1	Black, White,		
2	urs a	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2	2 <b>K</b> No	Specify:			Sp	ecify: Asia	ın	
Ş	within 72 hours after death with the Maryland ene. Itan "natural", or itema 23a or 28a-f ahow the Madical Exarranar must be molified at	Completed	15. Decedent's Edu (Specify only highest grad		Sa. Deced	dent's Usua kind of wor	i Occupa	ation	t of workin		16b. Kind	of Business/In	dustry	
2	thin 7 e.	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT us	e retired,	)				_	_	
7	filed wi Hygien Sther th	Co		4 Years	Hosp	ital	Unit					chcare	Servi	ces
Maryland 21215-0036	S is a S	To Be	17. Father's Name (First, Middle, Last) Thomas Drumhelle	er					r's Name seela	(First, Middle, I L Cheda				
Mary			19a. Informant's Name/Relationship (7) Chandrasekhar Drui	, BIODIOL		•	•			Route Number	-			
	1 and Health em 27 thar t		20a. Method of Disposition	20b. Place	of Dispo	sition (Nan	ne of	1				ion - City or To		
کّ	Peges nent of int: If its Irry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ntery, crer	natory or o	ther place	e) Cem-	4/14	/2006 A	delph	ni. Mar	v1and	
altimore,	it. P.		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens											
Ba	permit. Departn Imports any Inju		Nanny A.	leaen ly						AL HOME Ave, S		Spring		
		,	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. D ne cause on each line.	o not ent	ter the mod	e of dying	g, such as	cardiac or	r respiratory arr	est,		Approximat Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition	· Metastatio	ر (ر	astr	ic	Can	cer					
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):									
	Lammer	_	Sequentially list conditions,	b. Sepsis	().									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cue to (or s a consequent	ce ot):									
	and I-tran	xarr	that initiated events resulting in death) Last	c. Due to (or as a consequent	ce of):							-		
8760,	cate be executed obysicien and the burial-transit	calE			,-									
687	phys phys s the	dic		d										
×	that the death certific ed by the ettending p detached for use as	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy							230	. Date of delive	ery	
Box	etter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		∃Ectopic pr ∃ Other <i>(sp</i>						Month	Day	Year
P. O.	the d y the	ysi	1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	9□ Unknown										
	The law requires that the death certificate be executed ate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	by Pi	Part II. Other significant conditions co	ntributing to death but not resultin	g in the u	nderlying c	ause give	en in Part I.	•			contribute to t	he cause of o	
ord	w requires t been signe should be	ted								1 U Y	es 2	10 3   FIO	Dably 4	
ပ္ပ	e law i	Completed								24a. Was a autop:	SV		psy findings impletion of c	available ause of
<u> </u>	The ate h	5								perfor 1 ☐ Yes	2. NO	death? 1 ☐ Yes	2□ No	
ita	Physician: The this certificate hural director, page	Be	25. Was case referred to medical examiner?				10"		of Death	(Check only or	1e)			
$\leq$	Physic this c al dire	မ	1 Yes 2 No		Outpatier		-	4 U NU		ne 5 Resid			fy)	
בֻ	ding P. After t	on:	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time o Injury		28c. Injun Worl			28d. Describe h	ow injury o	ccurrea		
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	00 81 (1-)	· · · · · · · · · · · · · · · · · · ·	M		Yes 2□		28f. Location (S	trant and A	lumbor or Pus	al Pauta Num	bor
Division of Vital Records,	al or Attends after death	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, rarm, st	reet, ractory	у, опісе		Í	City or Tow		rumoer or num	ai noute ivali	1001,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, deat and/or in	th occurred evestigation	at the tin	ne, date an pinion, dea	nd place, a oth occurre	and due to the d ed at the time, o	ause(s) an	d manner as s ace, and due t	stated. o the cause(	s)
	To the within 2	Me	29b. Signature and title of certifier					e number		i		igned (Month,		
			N	10		-	DYT	717	<del>(</del>		4	10/00	0	
	7		30. Name and address of person who o	completed cause of death (Item 23	Ba) (Type,	, Print)					0 1		-0:-	
	3		Bobby S. ]	David MO,		7610	Car	all A	ie, T	Takoma	Yor K	'WD 3	2140	•
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature		Carle	,							

			For State Registrar	State of Mar		artment of He		lental Hygiei	.000	13435
¥.	Physici		1. Decedent's Name (First, Middle, Las	st)				Date of Death     Month	Day Year	3. Time of Death
	/Medic		Barbara Jean	Combs De	an			April 12,	2006	7:58 a.m.
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or I		THE SAME OF THE SAME OF	4c. County of Dea	_
100			50025 Hays Beach 5. Social Security Number 6. S		In yrs. last birthday	Sco If Under 1 Year	tland If Under 24 Hrs.	8. Date of Birth		Mary 's rthplace (State or Foreign
	Funeral Director			M 2QXF	66 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ar) C	ryland
			Usual Residence of Decedent		00			11-13-19.	J9 Ha	ryrand
	yland		10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	a-1-e	ctor	Maryland St. M	ary's		Scot1a	nd			1 ☐ Yes 2 XNo
	or 28	)ire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	23a	Funeral Director	50025 Hays Beach	Road		206			United S	tates
	r dea	Tue	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spanic Origin?) n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	or if	by Fi	1 ☐ Never Married 2 ☐ Married  3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:		Specify:	White
Ö	72 hours after death with the Maryland naturel; or iteme 23a or 28e-f ehow dical Examinat must be notified at	pa pa	15. Decedent's Ec	Year or Dates:	16a Dece	dent's Usual Occupa	tion	16h	. Kind of Business	s/Industry
<del>1</del> 5	in 72	Completed	(Specify only highest gra	de completed)	(Give	kind of work done du DO NOT use retired)	uring most of work	ing	. King of business	sindustry
12	within lene. then "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Nurse			Hea1	thcare
b	e filed within at Hygiene. other then '	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Maid		
a	should be nd Mental marked o	To B	Arthur Combs				Lena	Davis		
Maryland 21215-0036	should and Men marke		19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (Street at	nd Number or Rura	al Route Number, Ci	ty or Town, State,	Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23s or 28s-f show or other treumetic event, It a Medical Examinar man be notified at		John W. Dean / S	on		5 Hays Bea				
ore	of He		20a. Method of Disposition 1 XBurial 2 Cremation 3 C	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	9)	Date 20c	. Location - City o	r Town, State
Ĕ	Pages ment of ant: if it ury or o		4 □ Donation 5 □ Other (Specify			ael's Cem.			idge, Ma	
Baltimore,	permit. Page Department Important: if eny injury o		21. Signature of Funeral Service	15ee	2	2. Name and Address	s of Facility Bri	nsfield F	uneral H	ome, P.A.
_	20599	Ш	Edward N. Brinsfi		100052 2:	2955 Holly	wood Roa	d, Leonard	dtown, M	20650-0279
The state of			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	ne death. Do not er	iter the mode of dying	, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
ć.	Physician		Immediate Cause (Final disease or condition	a			+			and boar
165	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		1.0	Ø		/n = h
100	Examine:	_	Sequentially list conditions,	b. Free to for sea.	Mon	ang Pa	UW L			TRU
	ed ssit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cise to (ci and	Viola	S = F	to Do	111		Hails
	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a	concernence of):	our !	The state of	HO.		Lag
8760,	be e sician buria	icai			Ken	al For	Vun	1		W
687	ficate phys s the	edic		_ d	1000	n Ta				11
Box (	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	eliv
	death a atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at tir		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.0.	t the de by the a	Physician/M	9 Unknown	9□ Unknown						
	res that igned I be det	by P	Part II. Dther significant conditions of	contributing to death but	not resulting in the	underlying cause give	n in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ğ	w require been sig should b							1 🗆 Yes	2 <b>1</b> No 3 □ F	Probably 4 Unknown
Records,	awre is be 2 sho	piet	72					24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
Ä	The lav	Completed						performed	death?	_
Vital		BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
of V	Physician: this certific ral director,	70	1 ☐ Yes 2 € No	Hospital: 1 Inpatient	2 ER/Outpatie		4   Nursing Ho	ome 5 Residence	e 6 □Other (Sp	ecify)
0 0		1	27. Manner of Death 1 27Natural 5 ☐ Pending	28a. Date of Injury (Month, Day 1	(ear) 28b. Time Injury	Work	at ?	28d. Describe how i	njury occurred	
Division	n a a	Certification:	2 Accident investigation				′es 2 □ No			
Ξ̈́	of Attendate death of after death of the ctor:	Ę	3 Suicide 6 Could not b 4 Homicide determined		/ - At home, farm, s ( <i>Specify</i> )	treet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
Ω	oital ours at									
	To the Hospital or Attention 24 hours after de To the Funeral Directo completely filled in by the	Medical	(Check only 2 Medical Exam	nysician: To the best of miner: On the basis of e	xamination and/or i					
	thin 2 the mple	Med	29b. Signature and title of certifier	and mariner state	7	29c. License	number	29d.	Date signed (Mor	nth, Day, Year)
	To To		In a sale	appl land	AA 1	1	NEUI	9	11_14	21
7			Karris	X / NOVY	10 / 10 m	<u>J</u>	UD TI		7-10	00
			30. Name and address of person who James P. Jarboe,	1 1/		Notch Road	Но11	ood Marri	land 2043	36
80	Sta	ato.	31. Date filed (Month Day, Year)	2. Registrar	s Signature		, HOTTAM	oou, maryl	Land 2003	,
	Regist									
DH	HMH 17 Rev 1/2	2001	MFR 1 1 2	006	10 19					1 10 12

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		State of Ma	arylan			nt of H <i>te of l</i>			fental Hy	/giene Reg. No	UUU	epin-orpité diffesée	343	6
			Decedent's Name (First, M.	iddle, Last)							_	2. Date of D Month	eath Day	v Y	'ear	3. Time of t	Death
	Physici /Medic		Jack Elliot	t								April	10	200	06	6:25	A. M
	Examin		4a. Facility Name (If not instit	ution, give s	treet and number)			4b. Cit	y, Town, or	Location	of Death			. County of			
		300	Montgomery					16.1.1.	01ne	,	- 0.1 ()			lontg			
48	Funeral		5. Social Security Number	6. Sex	7. Ag M 2□F	e (In yrs. 85	last birthday) Yrs.	Months	or 1 Year Days	Hours	Min.	8. Date of B (Month, D	rth ay, Year)			lace (State or try)	Foreign
	Director		089-24-6028 Usual Residence of Deceden				113.				1	May 1	+ <b>,</b> 19	120   1	lew_	York	
	and and		10a. State 10b. Cor			10c. Cit	y, Town or Lo	cation							1	0d. Inside City	y Limits
	Mary f sh	ខ្ម	Maryland Mor	tgome	ry	Br	ookevi	11e								1X Yes	2 🗌 No
	the	rec	10e. Street and Number					10f. Z	ip Code				10g. Cit	izen of Wh	at Coun	try?	
	3a O	0	20001 Georgia	Aven	ue				2083	33				U. S.	. A.		
	ms 2	era	11. Marital Status	1	2. Was Decedent	Ever in U	.S. 13. \	Nas Dec	edent of H	ispanic C	Origin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race -			
36	be filed within 72 hours after death with the Maryland ital Hygiene death with the "netural", or items 23s or 28s-f show of other than "netural", or items 23s or 28s-f show event, Its Medical Exercises must be retilised at	Completed by Funeral Directo	1 ☐ Never Married 2X 3 ☐ Widowed 4 ☐ Divo		Armed Forces?  1 X Yes 2 1 If Yes, Give Year or Dates:		ore		ecity Cuba 2 <b>∑</b> No	Specif		Hican, etc.)		Specify:	White, Wh	ite	
8	hour tural	ed t		edent's Educ		WW Z	16a. Deced	ient's Us	ual Occup	ation			16b. K	ind of Busi	ness/Ind	dustry	
5	in 72	siet	(Specify only hi	ghest grade	completed)		(Give	kind of w	rork done o use retired	during mo	ost of work	ing	, , , , , ,			,	
12	within lene. than	шо	Elementary/Secondary (0-	12)	College (1-4or 5		Dr	ivir	ng Scl	hoo1			1	Instr	ıcto	r	
9	e filed within the Hygiene. other then vent, It o Missione.		17. Father's Name (First, Mic	ldle, Last)	2 1001				8		her's Nam	e (First, Middl	e, Maiden	Sumame)			
<u>lan</u>	uld be Aental rked o	To Be	Herman Ellic	tt							Ma	e Musc	rat				
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 1s marked any injury or other treumatic evones.		19a. Informant's Name/Relate Sally Elliot									al Route Num. Brook					833
Ē,	thea thea item		20a. Method of Disposition				Place of Dispo			(e)		Date	20c. L	ocation - C	ity or To	wn, State	
Ë	Page nent c int: If iry or		1 Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe		emoval from State		lean Me	-			4/12/	2006	01ne	ey, Ma	ary1	and	
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Ser	vice License	°		Ed	. Name . Ward	and Addres	ss of Fac	unera	1 Dire	ction	ı, Inc	а.		
	897	7. 9	Oonald	C	tottle	my	er 10	91 I	locky	ille	Pike	. Rock	ville			nd 20	852
	Physician /Medical Examiner		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only on	e cause on each li	Cord	nary A					orrespiratory	arrest,		\$e	Approximate Interval Betw Onset and D	een eath
38760,	icate be executed physician and sthe burial-transit	ai Examiner	Sequentially list conditions, fl any, readong to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	Due to (or as												
87	physis the	dicai		d						_				_			
.O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t 23	3c. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 Feta	death 3	Ectopic Other (	pregnancy specify)					23d. Date Montl		-	<b>9</b> ar
S, D	es that igned b	by Pt	Part II. Other significant cor		tributing to death b	ut not res	ulting in the u	nderlying	ı cause gıv	en in Par	rt I.		_	_		ne cause of de	1
ord	w requir been si should		_ Hyperkalemia	a								1	Yes 2	NO 3	∐ Prob	ably 4 □U	nknown
Vital Records,	The law rate has be page 2 sh	Completed	Peripheral '	Vascul	ar Disea	se						per	s an opsy formed? 2 X No	pri de	or to cor ath?	psy findings a npletion of ca 2 \( \text{No} \)	vailable luse of
		0	25. Was case referred to me	dical						26. Pla	ice of Deat	h (Check only					
>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🙀 No	Н	ospital: 1 y patie	ent 2	ER/Outpatier	nt 3 🗆 i	Oth Oth	er: 4 🗌	Nursing Ho	ome 5 Re	sidence	6 Other	(Specify	v)	
	After Anne		27. Manner of Death 1 ⊠Natural 5 □ Pe		28a. Date of Inju (Month, Da	ry y Yea <i>r)</i>	28b. Time o Injury	f M	28c. Injur Wor	y at k? Yes 2	□No	28d. Describe	how inju	ry occurred	1		
Division	or Attention ter deat Irector:	Certification;	3 ☐ Suicide 6 ☐ Co	vestigation ould not be itermined	28e. Place of In	ury - At h c. <i>(Speci</i>	ome, farm, str (y)					28f. Location City or T	(Street arown, State		or Rura	I Route Numb	08 <i>r</i> ,
_	To the Hospital of within 24 hours af To the Funerel D completely filled in	Medical C			sician: To the best ter: On the basis of and manner st	f examina											
	o the o the omple	Me	29b. Signature and title of ce	ritier				2	9c. Licens	e numbe	or .		29d. Da	ite signed	Month,	Day, Year)	
	F 3 F ŏ		1						0006	46.15			4)1	c/00	e D		
	11		30. Name and address of pe	rson who co	mpleted cause of o	leath (Ite	n 23a) (Type.	Print)	0 00	( ایت				1		20832	
	19		Dr. Frede						ilip	Driv	e, Su	ite 10	0, 0	lney,	Mar		
	St		31. Date filed (Month, Day, 1)		32. Pagistr			poets									

		1 - For State Registra AMEND 23e, 24a&b,	State of Maryland / I				Mental Hy	giene)) 6	13437
		Decedent's Name (First, Middle, Last)		1-200	<u></u>		2. Date of De	ath	3. Time of Death
Physic		Lawrence Me	lvin Foster,	, Sr			April	2,2006 Year	1:20 AM
/Medi Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of De	
	je .	Southern Maryl	and Comm. Hosp	oita	al Clir	ton		Prince	George's
Funeral Director	,	5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Bir (Month, Da Oct. 2	th 9. E	Birthplace (State or Foreign Country) Virginia
P.		Usual Residence of Decedent							
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or iteme 23a or 28a-f ahow sumatic event, the Medical Exonic activation in the marked at	<u>_</u>	10a. State 10b. County MD Prince 0	10c. City, Tow	m or Loc int					10d. Inside City Limits 1 X Yes 2 ☐ No
88-1-88	Director		leorge 5 cr		т			40 000	
with ti		10e. Street and Number	7-11err Tame		10f. Zip Code 2073	5		10g. Citizen of What USA	•
e 234	Funeral	9416 Stream V		12 14			Spoots Van as No		merican Indian.
itam itam	une	11. Marital Status  1 Never Married 2X Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (28No	IS. VI	as Decedent of Hi Yes, specify Cubar	n, Mexican, Pue	nto Rican, etc.)	Black, W	
rrs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 🖾 No	Specify:		Specify: E	Black
2 hou	ed	15. Decedent's Edu	cation 16a	. Decede	ent's Usual Occupa	ition		16b. Kind of Busine	ss/Industry
n 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-40r 5+)	(Give k	rind of work done d O NOT use retired, hnical	uring most of w	orking	Dont of	+ho Navy
d with	E	Elementary/Secondary (0-12)	College (2-4or 5+)	Tec	nnicai	Engine	er	Dept.or	the Navy
m - 0 5	BeC	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
Jid be Jental rked o	ToE	Robert Levi I	Foster, Sr.			Jane	Willis	5	
d 2 should be filed within 72 hours aft thand Mental Hygiers than and the standard of the marked other than "natural; or traumatic event, the Medical Exami	-	19a. Informant's Name/Relationship (T)						er, City or Town, State	
and 2 alth 27 i		Patricia Rawl:	ngs(Epstee) 9	416	Stream	Valle	y La.,	Clinton,	MD 20735
Dermit. Pages 1 ar Depertment of Hea mportant: if item any injury or other once.		20a. Method of Disposition	20b. Place of cemete	of Dispos	ition (Name of atory or other place	e)	Date	20c. Location - City	
Pages nent of I ant: if it	4	1 ☐ Bunal 2 ☐ Cremation 3 ☐ F 4 ☐ Conation 5 ☐ Other (Specify)	Foste	r F	amily C	em. 04	/11/06	Wicomico	, VA
permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 is marked any injury or other traumatic en ODGS.		21. Signature of Funeral Service Licens	Chams	223	Name and Addres 831 Geo	s of Facility I	atney ve.,NW	Washing	tton, pc 120
Physician   Medicate pe executed   Physician   Physician   Physician and   Physician as the burial-transit	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to milineurate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence	of):	2DIAL 1	WFACT			
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ∐Live birth 2 ∭ Fetal death 4 ∭ Pregnant at time of death 9 ∭ Unknown		Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
uires that signed b id be deta	D D	Part II. Other significant conditions co	•	in the un	derlying cause give	on in Part I.			e to the cause of death?  Probably 4 Munknown
or Attending Physician: The law requires that the death certails death certails death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Completed	CONGESTIVE	HEART FAILUI	2€			24a. Was auto perfo 1 Yes	psy prior to prmed? death	autopsy findings available to completion of cause of ?
an: tifica tor, p	a)	25. Was case referred to medical				26. Place of D	eath (Check only		
ysici is cer direc	To B	examiner? 1 ☐ Yes 2 점 No	Hospital: 1 ☐ Inpatient 2: ☐ ER/O	utpatient	3□ DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Resi	dence 6 □Other (S	pecify)
tending Physician: The Jeath. tor: After this certificate hit the funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of Injury	28c. Injury Work	at t? Yes 2 □ No		how injury occurred	
i or Attenation after deation Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, stre	et, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Cartifying Phy (Check only one)	sician: To the best of my knowledg nar: On the basis of examination a and manner stated.	je, death nd/or inv	occurred at the timestigation, in my op	e, date and place pinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
othin othin ompli	₹ E	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	
⊢≯⊢ŏ		1 Joseph			Do	10324		APRIL 3,	2006
10		30. Name and address of person who co	ompleted cause of death (Item 23a)	(Type, F	Print)			IARYLAND	
St Regist	ate	31. Date filed (Month, Day, Year)					-		

		1 - For State Registrar	State	of Marylai		artment tificate			Mental H	ygiene Reg. No	. 00	5	3	138
HEAVY.		Decedent's Name (First, Middle, I	Last)	· · · · · · · · · · · · · · · · · · ·					2. Date of D	eath		Vass	3. Time	of Death
Physicia /Medic		Saul Fein	berg						April	1 ^{Da}	, 2	Ŏ06	5:45	A. M
Examin	er	4a. Facility Name (If not institution, of			rton		wn, or Lo V <b>il</b> l	ocation of De	ath		County		2017	
	8	Hebrew Home of  5. Social Security Number 6	. Sex		. last birthday)	If Under 1		Under 24 H	rs. 8. Date of 8	lirth	Mont			or Foreign
Funeral Director		112-03-7201	1√ M 2□ F	88	Yrs.	Months (	Days	Hours M	Jan.	Day Voarl	918	New	lace (State try) York	or r oreign
Pu .		Usual Residence of Decedent		10.0										
laryla •hov	5	10a. State 10b. County			ity, Town or Lo							1	0d. Inside (	Sity Limits
the N 28a-f	ect	Maryland Montgo	mery	Ro	ockvill	e 10f. Zip C	ode			10g Cit	izen of W	hat Cour		
3a or	ā	6121 Montrose Ro	ad				852				U. S		, .	
death	Funeral Director	11. Marital Status		cedent Ever in U	J.S. 13. \	Was Deceder	of Hispa	anic Origin?	(Specify Yes or Nerto Rican, etc.)	10-		- Americ	an Indian,	
or Itu	by Fu	1 Never Married 2 Married	1 1X Yes	2 □ No A	rmy	Yes 2X		Specity:	onto riioani, oto.,		Specify:	T.T	hite	
hour	ed b	3  Widowed 4 □ Divorced  15. Decedent's	_	Dates: Kore		ient's Usual (	Occupation	20		16h Ki	ind of Bu	sinese/ln/	dusto	
n "na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	(Give	kind of work DO NOT use	done duri retired)	ing most of v	vorking	100. 10	ind of bu.	3111033/1110	lustry	
od with	Som	ciomontary/socondary (5 12)		ears	Sa	lesman					Furn	itur	e	
Lat y idition Z 1Z 12-0030 2 should be filed within 72 hours after death with the Maryland and Manila Hygene. le marked other than "natural", or Itama 23a or 28a-1 show aumatic event, the Madical Examiner must be notified at	Be	17. Father's Name (First, Middle, La					18		lame (First, Middl			9)		
y I d	P	Morris Feinber	_		105 11-8-	- 444 //			adie Hore					
d 2 st d 2 st th and traun traun		19a. Informant's Name/Relationship		l- 4					Rural Route Num				2210	1
te, IV		Marcia F. Cohn 20a. Method of Disposition	_ Daug	20b.	Place of Dispo cemetery, cren	sition (Name	of	a Coul	ct, McLea				wn, State	<u> </u>
Pages nent of in the introducery or o		∑☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ng Davi			s   4-1	L4-2006	Fa1	ls C	hurc	h, Vi	rginia
peritinities in the planta of the field within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene.  Department of Health and Mentall Hygiene.  By injury or other traumatic event, the Medical Exercities must be notified at an and the continuer.		21. Signature of Funeral Service Lic	censee		22	Name and	ddress c	of Facility O I d be 1	rg Memor:	ial C	hape	1s.	Inc.	
0 89EE9	0.0	Donald (.	Stote	tenny	1	170 Ro	ckvi	11e P:	ike, Rocl	kvill				20852
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that ity one cause on	caused to dea each line.	ith. Do not ente	er the mode of	of dying, s	such as card	iac or respiratory	arrest,			Approxima Interval Be Onset and	etween
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		oronary		Disea	se							
Examiner				o (or as a conse ongesti		t Fail	ure							
	er	Sequentially list conditions, if any, leading to immediate	b	) (or as a conse										
cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. A	trial F	ibillat	ion								
of ou, cate be executed bhysicien and the burial-transit	Ex	resulting in death) Last	Due to	o (or as a conse	quence of):									
cate be executed physicien and the burial-transit	dicai		d											
w requires that the death certific been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregn	ancy						23d. Date	of delive	201	
death a atter d for u	iciar	in the past 12 months?	1□Live 4⊡Pre	birth 2 ☐ Fet gnant at time of	al death 3	]Ectopic preg ] Other (s <i>pec</i>					Mon		Day	Year
by the tache	hys	9 Unknown	9□ Unk	nown										
es tha igned be de	ру Р	Part II. Other significant conditions					se given i	in Part I.	_		_		ne cause of	
w requires I	ted	Gastroenteritis			ementia				- 1	Yes 2	XNo	3 Prob	ably 4	]Unknown
e taw has b	ompieted	Peripheral Vaso	ular Di	sease					24a. Wa aut	s an opsy form <u>e</u> d?	Pi	ere autor for to coreath?	psy findings mpletion of	s available cause of
cian: Th	O	OF Man and advantage of the second							1 ☐ Yes	2X No		Yes	2 No	
sicial s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	] ER/Outpatien	t 3 DOA	Othor		eath (Check only		e 🗆 Otho	- /C===i4	.)	
g Phy er this eral d	<b>-</b>	27. Manner of Death	28a. Date	e of Injury	28b. Time of		Injury at Work?		Home 5 Res				9	
Attending at death.  ector: Afte by the fune	atio	1 Natural 5 Pending 2 Accident investigat	ion	min, Day 19ai)	Injury	М		2 □ No						
r Atter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ad 289. Plac	ce of Injury - At I	nome, farm, stre	eet, factory, o	ffice		28f. Location City or To	(Street an own, State	d Numbe	r or Rura	l Route Nur	mber,
pital of		29a. Certifier 1 Certifying	Dhusisian T a		1- 4- 4 4									
Hos 24 ho Fun etely f	Medical	(Check only 2 Medical Ex	aminer: On the	ne best of my kn basis of examin inner stated.	ation and/or inv	estigation, in	my opini	date and pla on, death oc	ice, and due to the curred at the time	e cause(s) e, date and	and mar I place, a	ner as st nd due to	ated. the cause(	(s)
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours attending Physician: The law requires that the death certific to the Funcated Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier	-			29c. L	icense nu	umber		29d. Dat	e signed	(Month,	Day, Year)	
0			V	Dulk M	D		0057	884		Apri	1 11	, 20	06	
3		30. Name and address of person who Dr. Damien Do	~				tree	t, Ro	ckville,	Mary	1and	208	52	
Sta Registr		31. Date filed (Month, Pay Year)	2006 32.	Pigistrar's Sign	ature A	noste								

		- State Registrar	te of Marylar		tment o				g. No.	96	13439
Physician /Medica Examine	al	Decedent's Name (First, Middle, Last)     CHRISTOPHER HARRY      4a. Facility Name (If not institution, give street au	1 1		4b. City Jov	wn, or Locati	on of Death	A pril	Day //, o	Year OO 6	3. Time of Death 13 4-5 M
Funeral Director		Memorial Hospital  5. Social Security Number  170-12-8602  6. Sex  101 M 20	7. Age (In yrs.	last birthday)	If Under 1 Y Months D	,	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, APRIL 2	Year)	9. Birthi Coul PENI	Tolace (State or Foreign ntry) VSYLVANIA
death with the Maryland ms 23e or 28e-1 show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD QUEEN ANNE		ty, Town or Loca							0d. Inside City Limits 1 ☐ Yes 2X No
th with the	Funeral Director	10e. Street and Number  104 TAYLOR DRIVE			10f. Zip Co	1658		10	g. Citizen of USA	What Cou	ntry?
336 irs after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a after in a aft	٦	1 Never Married 2 Married 1 N	Decedent Ever in Used Forces? Yes 2 Noss, Give r or Dates: 1943-	1.0	as Decedent Yes, specify			ecify Yes or No- Rican, etc.)		ce - Americack, White,	
nd 21215-0036  nd 21215-0036  al Hygiene. lother than "naturel; or vent, the Madical Exam	Completed	15. Decedent's Education (Specify only highest grade compl  Elementary/Secondary (0-12)  8	eted) ege (1-4or 5+) -0-	16a. Decede (Give ki life. Do	nd of work a D NOT use r	lone during i etired)	nost of worki	ing	EXCAVA		dustry
Maryland Maryland d 2 should be file inth and Mental Hy 77 is marked oth traumatic event	To Be (	17. Father's Name (First, Middle, Last) CHARLES ADAM GOSS					IVA MI				
e, Mar. 1 and 2 sho		19a. Informant's Name/Relationship (Type, Prin VIRGINIA L. MARTIN/ D.	AUGHTER	220 HI	JNTERS	VIEW	LANE,	CENTREV	ILLE,	MD 21	617
	1	20a. Method of Disposition  1   MBurial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State	Place of Disposi cemetery, crema STERFIE	itory or other	r place)	1		CENTRE	-	
Baltime Permit. Pag Department Important: Important: Any Inlury o		21. Signature of Funetal Service Licensee	e the					& NEWNA			IOME,P.A.
by Sician by Sician and Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street of Street	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.	that caused time deal a object line.  N TYO CUMO use to (or as a consecute to or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or as a consecute to (or a))).	quence of):  thy quence	2000	ryhag	as cardiac c	or respiratory arre	St,		Approximate interval Between Onset and Death Day S
Vision of Vital Records, P.O. Box 6876( Attending Physicien: The law requires that the death certificate be solor: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the bur	Physician/Med	in the past 12 months?	es, outcome of pregna Live birth 2 Feta Pregnant at time of c Unknown	al death 3 🗆 E	ctopic pregr Other (specif					ate of delive	ery Day Year
rds, P.	۵	Part II. Other significant conditions contribution Atrial fibrillate	g to death but not res	sulling in the unc	lerlying caus	e given în P	art I.		acco use cor s 2 🗆 No		he cause of death?
Vital Record ician: The law requir certificate has been s rector, page 2 should	Completed	Hypertension							ned?	Were autoprior to codeath?	psy findings available mpletion of cause of
of Vita Physician: this certific	To Be	25. Was case referred to medical examiner?  1  Yes	1 Min patient 2	ER/Outpatient		Other: 4	Nursing Ho	n <i>(Ch</i> eck only one me 5 ☐ Reside	nce 6 🗆 Ot		(y)
Division of Vital Records, for Attending Physicien: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Certification:	2 Accident investigation	Date of Injury (Month, Day Year)  Place of Injury - At h building, etc. (Speci	28b. Time of Injury	М	Injury at Work? 1 ☐ Yes 2		28d. Describe ho 28f. Location (Str City or Town	eet and Num		al Route Number,
a s le o	Medical Cer	29a. Certifier (Check only one)  1 Certifying Physician: 2 Medical Examiner: On and	To the best of my kno the basis of examina d manner stated.	owledge, death a ation and/or inve	occurred at t	he time, dat my opinion,	e and place, death occurr	and due to the ca red at the time, da	use(s) and m te and place	anner as s	fated. o the cause(s)
To th To th comp	Me	29b. Signature and title of certifier  Labohani Varidye  30. Name and address of person who co	anathan	m 23a) (Type, P	20	S 7			PRIL		Day, Year) 2006
5 KK State Registra	100	LAKSHMIC VAIDYANATH.  31. Date filed (Month, Day, Year) APR 1 3 20	32. Registra/s Sign	ature			ST.,	EASTON,	MD 216	01	

DHMH 17 Rev 1/2001

·	ľ	For State Registrar	State of M	larylan		artment o				Reg. No.	06	entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entered entere
Physicia	ın	Decedent's Name (First, Middle,							2. Date of D Month	eath Day	Year	3. Time of Death
/Medic	al	Frances Elizab							April		006	5:00 P
Examine	er	4a. Facility Name (If not institution,	•					ocation of Death	7		unty of Dea	
Function		Wicomico Nu I  5. Social Security Number			last birthday)	Sal If Under 1		ury If Under 24 Hrs.	8. Date of Bi	rth	om i c	O tholace (State or Foreign
Funeral Director		218-16-9770	1□M 2X)F	83	Yrs.	Months C	Days	Hours Min.	Jan. 7	ay, Year) • 1923	Ma	thplace (State or Foreign buntry) ryland
P		Usual Residence of Decedent										
anylar show	_	10a. State 10b. County		10c. City	y, Town or Lo							10d. Inside City Limits 1X Yes 2 □ No
ith the Marylan or 28e-1 show	Director	Maryland   Wicomi	co		Salis							
Mith Co.	급					10f. Zip Co				10g. Citizen		ountry?
death death ms 23	Funeral	900 Booth Stre		t Ever in U.	S. 13.		2180		pecify Yes or N		USA Race - Ame	erican Indian,
or Iter		1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces d 1 ☐ Yes 2 🕅	? [No		_	_	panic Origin? (S , Mexican, Puert	o Rican, etc.)		Black, Whit	
5-0036 72 hours after natural; or Ite	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🗹	No.	Specify:		Sp	ecify:	White
21215-0036 21215-0036 of within 72 hours a riginal matural; of the Medical Exam	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usual C kind of work of	occupati done dui	ion ring most of wor	king	16b. Kind	of Business	/Industry
2121 2121 ad within /giene. er than "	mp	Elementary/Secondary (0-12)	College (1-4or	5+)	Trim		retired)			Cloth	ina M	anufacturina
d 2.		8 17. Father's Name (First, Middle, La	ast)		TTTIII	ne L	1	8. Mother's Nan	ne (First Middle			anufacturing
and be sontail	To Be	Virgil Davis							Moore	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	riario)	
aryla should not Men of Men marke	F	19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailin	ng Address (S	itreet an	d Number or Ru		er, City or To	wn, State, 2	Zip Code)
Baltimore, Maryland 21215-0036  Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be nutified at once.		Charles Gochnour	/Son		9902	01d 0	cean	n City B	oulevar	d, Ber	lin,	MD 21811
ore, se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1 a se 1		20a. Method of Disposition	ПО		lace of Dispo	sition (Name a	of or place)		Date	20c. Locati	on - City or	Town, State
Page ment in mont in our o		1 XBurial 2 □ Cremation 3  1 4 □ Donation 5 □ Other (Spe		• [	_	hurch (		1	/2006	Walst	on Swi	itch, MD
Balti Permit. Departi Importa any inji	1	21. Signature of Fur ral Service Li	селяе	nn		2. Name and A			o D O	Dorr	2171	
m #9 = #9	1	Jeoneus	C 2	lle							ury, l	MD_21802
	-	23a. Parvi. Enter the disease, or construction shock, or heart failure. List or	omplications that cause nly one cause on each I	d the death line.	n. Do not ent	er the mode o	f dying,	such as cardiac	or respiratory a	ırrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	-a. ASCV	0								Onset and Death
/Medical Examiner		resulting in death)	Due to (or as		uence of):							
	<u>-</u>	Sequentially list conditions,	b. CHF  Due to (or as		uence of):							
uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(0,00	- O	Ande	i Ste	0.1	i'a				
execting an and rial-tra	Exa	that initiated events resulting in death) Last	C. Due to (or as	s a consequ	uence of):	0 00	000	-				
8760, cate be excopysician a	cal		d									
r 68 artifica ing ph	hysician/Medical	IF FEMALE:										
Box eath cert attendin for use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregr				23d.	Date of dei Month	ivery Day Year
P.O. I	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9∐Unknown	at time of de	eath 5□	Other (specif	fy)			1	17101101	Day Tour
that the ed by detac	۵.	Part II, Other significant condition	s contributing to death t	but not resu	ulting in the u	nderlying caus	se given	in Part I.	23e. Did	tobacco use d	contribute to	the cause of death?
ds, uires	d by	Diaseles Me	Ulitas						10	Yes 2□N	o 3 □ Pr	obably Unknown
CO) W rad	iete	HTN.							24a. Was	an 24	4b. Were au	itopsy findings available completion of cause of
Re la la te has age 2	ompieted	leas To	N · - 2						auto perfo	ormed?	prior to death? 1 ☐ Yes	/
ien: Jen: rtiffica	O	25. Was case referred to medical	grany				2	26. Place of Dea			1 1 105	20110
hysic hysic his ce	ToB	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 🗆 I	ER/Outpatien	t 3 DOA	Other:	4 Nursing H	ome 5 Resi	dence 6 🗆	Other (Spec	city)
ng Pl		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury		Injury a Work?	t	28d. Describe			
SiO trend tor: /	cati	2 Accident investiga 3 Suicide 6 Could no	t bo			М		s 2 No	00/ 1			
Division of Vital Records, or Attending Physicien: The law requires ta after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	ertification:	4 Homicide determin		tc. (Specify	me, farm, str	eet, factory, of	ffice		City or To	Street and Ni wn, State)	umber or Hu	ıral Route Number,
Spital ours ours in illed	ပ	29a. Certifier 1 Certifying	Physician: To the best	of my know	wiedge, death	occurred at t	he time	date and place	and due to the	cause(s) and	l manner as	stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Ex	caminer: On the basis of and manner st	of examinat	ion and/or inv	estigation, in	my opin	nion, death occur	rred at the time,	date and pla	ce, and due	to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	$\wedge$				icense n			29d. Date sig	gned (Monti	h, Day, Year)
		* Ylen	J A			Do	006	:3199		4/11	06	
		30. Name and address of person wi	no completed cause of	death (Item	23а) (Туре,	Print)				1		
		Yogesh Vohra	M.D. 614	Eas	terns	shore	Dr	Salist	oury MI	2180	04	
Stat Registra	5 4	31. Date filed (Month, Day, Year)				Asset	0					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 10, Day 2006 Year **Physician** Mary Evaughn Gignac 6:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 320 Dares Wharf Road Prince Frederick Calvert County 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Oct. 8, 1937 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 27 F 577-52-0757 68 Yrs Director Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or 28a-f show The Medical Examiner must be notified at 1 Yes 2 No Directo MD Calvert County Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 320 Dares Wharf Road 20678 U.S.A. Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White à 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Plumbing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Glenn Clifton Olsen Dorothy Fairfax ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau 320 Dares Wharf Road, Prince Frederick, MD 20678 Raymond P. Gignac (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aprilate14. 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 2006 Cheltenham, Maryland 21. Signature of Fundation 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lee Michael 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREAT CANCER Physician /Medical Examiner Sequentially fist conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2X No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached for 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should ! 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2 No Other: P 1 fnpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA siyi After this funeral o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation injury death. 1 TYes 2 No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23 y (Type, Print) CHRISTIAN 401 NORTH BROADWAY, BALTIMORE, MARYLAND MEYER 31. Date filed (Month, Day, Year) 32. Registre s Signature State 2005▶ Registrar

			For State Registrar	State of M	aryland	-	artmen <i>tificat</i>				ental Hy	giene Reg. No	-	- Constant	142
1	1.5		1. Decedent's Name (First, Middle, I	ast)							2. Date of De Month	ath Da	ıy Ye		of Death
	Physici /Medic		Virginia Gill									11,	, 2006	8:1	5 A ^M
	Examin		4a. Facility Name (If not institution, g						Location	of Death		40	. County of E		
			Frederick Memo			n n d	F'Y'€	deri	CK. If Under	24 Hrs	8. Date of Bi	db.	Frede		
	Funeral Director		5. Social Security Number 214-10-4093  Usual Residence of Decedent	Sex 1 ☐ M 2 X F 7. A	85 85	ast birthday) Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year,	920 N	Birthplace (Star Country) [arylanc	
	land ow	Ì	10a. State 10b. County		10c. City	, Town or Lo	cation		_					10d. Inside	City Limits
	72 hours after death with the Maryland natural; or Items 23s or 28s-f show Jical Examination must be rollified at	ţ	Maryland Fre	ederick		Fred	erick							1 <b>½</b> 1Y	es 2 □ No
	or 288	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wha	t Country?	
	23a c	a	1705 West Seve	nth St./ A _l	pt. 10	)3		2170	1			Uni	ted S	tates	
	r dea	nei	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Deced	tent of Hi	ispanic Ori n, Mexicai	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	o-		American Indian Vhite, etc.	
36	or it	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give	No		1 🗌 Yes	2 <b>/</b> No	Specify:				Specify:	White	
Ö	hour	pe pe	15. Decedent's	Year or Dates:		16a. Dece	dent's Usua	al Occupa	ation			16b. 8	Cind of Busine		
15	n 72 ni	plet	(Specify only highest	rade completed)	5.)	(Give	kind of wo DO NOT us	rk done d	turing mos	t of worki	ng			,	
21215-0036	within jiene r than	Completed	Elementary/Secondary (0-12)	College (1-4or 1	5+)	Cus	todia	1 se	rvice	es		Fed	eral 0	overnme	nt
p	e filec othe vent,	Be C	17. Father's Name (First, Middle, La	st)					18. Moth	er's Name	(First, Middle	, Maidei	n Sumame)		
/lar	Venta	ToE	Walter	Warren	Wa1	L1ace			Gra	ace E	linore	Vir	ginia	Moberly	·
Maryland	12 should be filed within " h and Mental Hygiene. 7 is marked other than " traumatic event, IL a Mac		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numb	er or Rura	I Route Numb	er, City	or Town, Sta	te, Zip Code)	
	and ealth m 27		Earl F. Gill / s	son	201 8		Jim		r Rd.		wnan,	GA	30263		
Baltimore,	t of H t of H if Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	CE	ace of Dispo	natory or o	ther plac						or Town, State	
ţi	tmen tant:		4 □Donation 5 □ Other (Spe		Mot	int OL					/2006			,Maryla	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show amportant of the Traumatte event, Ite Madical Examinar mant he rollified at once.		21. Signature of Funeral Service Lic	Gelees	m)	1	2. Name an 621 0				ke/ Fr				)2
	Physician		23a. Part1. Extent the disease, or co shock, a heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on each	ine.	My	er the mod		1		r respiratory a			Approxir Interval Onset a	nate Between nd Death
	/Medical Examiner		, and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of	Due to (or a	s a consequ	ience of):									•
#		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequ	ience of):			-						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
o,	eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last	Due to (or a	s a consequ	ence of):									
8760,	te be ysicia ne bu	edicai		d											
9	ntifica ng ph as th	Jed	IF FEMALE:												
Вох	th ce tendii	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Fetal	death 3	Ectopic pi						23d. Date of Month	delivery Day	Year
	TO O D	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of de	eath 5	Other (sp	ecify)						,	
P.0	requires that the de een signed by the a nould be detached t		Part II. Dther significant condition	contributing to death	but not resu	ultinos in the #	nderlyina a	ause giv	en in Part	l.	23e. Did	tobacco	use contribu	te to the cause	of death?
ds,	signe d be	d by	Arte Lowe	r Gastro	entes	stines	BI.	فعلا			10	Yes 2	No 3[	Probably 4	Unknow <i>π</i>
Ö	- Q 70	Completed by	Del ster and	litur +	no T		0.00	+0	2512		24a. Wa	s an	24h Wer	e autonsy finder	os available
Re	e las has ye 2	m d	Maserisine	1 20.11	YIA	, ,	YPU	10	1210	3)	auto		prio		of cause of
ā	i <b>ician</b> ; Th certificate rector, pag	e Cc	25. Was case referred to medical	ace the	1150	Ju .			26 Place	e of Death	1 Yes		0 1 1 1	Yes 2□ No	
>	Physician; this certific ral director,	0 B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 1 Inpat	ient 2 🗆	ER/Outpatie	nt 3□ D0	Oth-	200		me 5 ☐ Res		6 ∏Other (	Specify)	
o	g Phys er this eral dir	n: T	27. Manner of Death	28a. Date of In	urv	28b. Time o		28c. Injur		-	28d. Describe		-	· · · · ·	
io	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending investiga	tion	ay / 5a./	mary	М	1 🗆	Yes 2	No					
Division of Vital Records,	or Atterde.	Certification:	3 Suicide 6 Could <i>n</i> o 4 Homicide determin	28e. Place of It	njury - At ho etc. <i>(Specif</i> y	me, farm, st	reet, factor	y, office			28f. Location City or To			r Rural Route N	lumber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical Ce		Physician: To the best aminer: On the basis and manners	of examinat										se(s)
	omple	Me	29b. Signature and title of certifier	1 -			29	c. Licens	e number			29d. D.	ate signed (A	fonth, Day, Yea	r)
	/		m. I	Lamo	MM			D.	219	44			4/11/0	)(,,	
	5		30. Name and address of person w	no completed cause of								_	4.7.1	11.	203
	-		The se	risin N	110.	1475	To	3.1	AU	e # 2	104	2000	krick	ban.	21702

State Registrar

			For State	. 10000			d / Depa	artmen	t of H	ealth a		lental Hy	giene		101	1 . ,
			Registrar  1. Decedent's Name (i	Time baidelle le	-41		Cei	rtificat	e of L	Death			10g. 110.	16	134	40
	Physici	an		,	,	an.						2. Date of Dea	Day	Year	3. Time of	
1	/Medi Examir		FRANKLIN  4a. Facility Name (If no					4b. City.	Town or	Location of	of Death	APRIL	14 2 4c. County	2006	7:14	P '''
	Exami	iei	ANNE ARUN						APOL					E ARU	VDFT.	
	Funeral		5. Social Security Num	ber 6. S	ex 7.		last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birti (Month, Day	1		lace (State or	r Foreign
	Director		213-34-73 Usual Residence of De	24	<b>X</b> M 2□F	69	Yrs.					FEB. 27	, 1937	MD		
	yland			Ob. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside Cit	ty Limits
	a-fsh	tor	MD	QUEEN A	NNE'S	ST	EVENSV	ILLE							1 ☐ Yes	2 🗶 No
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show disal Evaninat roust be portified at	Director	10e. Street and Number	er				10f. Zip	Code	-			10g. Citizen of	What Cour	try?	-
	s 23a	rai	9401 ROMA	NCOKE R					666				USA			
	ter de Itam	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li></ul>	217 Married	12. Was Decede Armed Force	es?	.S. 13.	Was Deced f Yes, spec	ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	an Indian, etc.	
936	urs al	by	3 ☐ Widowed 4 [		If Yes, Give Year or Date			1 ☐ Yes 2	No No	Specify:			Specif	·: WH	ITE	
21215-0036	72 ho natur iical	Completed	15 (Specify	. Decedent's Ed only highest gra	ducation		16a. Dece	dent's Usua kind of wor			of worki	na	16b. Kind of B	usiness/Ind	lustry	
2	within ene. then *	mpi	Elementary/Seconda		College (1-4	or 5+)	life. I	DO NOT us	e retired,	)	or works	9				
	filed v Hygie other t		10 17. Father's Name (Fin	st Middle Last			PRIN	TER		18 Mothe	r'e Name	(First, Middle,	NEWSPA			
an	ld be ental kad o	To Be	ROBERT BE	_10								TOLA CR		•		
Maryland	should ind Men s marka umatic	<b>-</b>	19a. Informant's Name				19b. Mailir	ng Address	(Street a			I Route Number			Code)	
	and 2	9	JANICE HO	LTMAN/W	IFE		9401	ROMA	NCOK	E ROA	D. S	TEVENSV	ILLE. M	D 21	666	
Baltimore,	it of He If iten or oth		20a. Method of Dispos 1 X Burial 2 □ C		Removal from Sta	1 ^	lace of Dispo emetery, cren	sition (Nan	e of		C	ate	20c. Location -			
ţ	t. Pag tment tent: ijury		`4 ☐Donation 5 [	Other (Specify	) /							/2006	STEVENS	VILLE	, MD	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show mortivity or other treumatic event, the Medical Examiner must be notified at ODG.		21. Sign 1 e of 5 nev	al Service Licen	See		,   <b>F</b>	Name and ELLOW 06 SH	S, H	ELFEN	BEIN	& NEWN CHESTER	AM FUNE	RAL 1	IOME, I	P.A.
N. T.	Prysician /Medical Examiner	ner	Immediate Cause (Fin disease or condition resulting in death)  Sequentially list condit if any, leading to imme	ions,	Due to (or	h line.	uence off:			dis		,	est,		Approximate Interval Betw Onset and D	veen
68760,	Attending Physicien: The law requires that the death certificate be executed rideath.  sclor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ledicai Examiner	that initiated events resulting in death) Last	iry	c. Due to (or	as a consequ	uence of):									
P.O. Box 6	w requires that the death certific been signad by the attending f should be detached for usa as	Physician/Med	IF FEMALE: 23b. Was decedent proint the past 12 mo 1 Yes 2 N 9 Unknown	nths?		n 2 ☐ Fetal tat time of de	death 3	Ectopic pre					23d. Dat	e of delive	-	ear
	equires tha en signad l	by	Part II. Other significations Congesti		ontributing to deat	lure	ulting in the ur	nderlying ca	use give	n in Part I.			pacco use contr es 2 □ No		e cause of de	
Division of Vital Records,	Attending Physicien: The law r er death. rector: Atter this certificate has be by the funeral director, page 2 sh	Completed										24a. Was a autops perform	ned?	rior to con leath?	sy findings av pletion of cau	vailable use of
Ž	sicier certif irecto	o Be	25. Was case referred examiner?	medical	Hospital:	otiont CO	ED/0	200	Othe			Check on on				
on of	ding Phy n. After this funeral d	tlon: To	27. Mann of Death 1 atural 5	☐ Pending investigation	28a. Date of I (Month,		ER/Outpatient 28b. Time of Injury		c. Injury Work	4 🗀 Nur	2	ne 5 🗆 Reside 8d. Describe ho				
Divisi	To the Hospital or Attending Phwithin 24 hours after death. To the Funarel Director: After this completely filled in by the funeral	Certification;	2 Accident 3 Suicide 4 Homicide	Could not be determined	28e. Place of	Injury - At ho etc. (Specify	me, farm, stre			03 2		8f. Location (St City or Town		er or Rural	Route Numbe	Θ <i>r</i> ,
	To the Hospital or within 24 hours afte To the Funarel Dir. completely filled in I	Medical (			ysician: To the be niner: On the basis and manner											
	To the within To the comp	M	29b. Signature and title	of certifier	1			29c.	License	number	1	2	9d. Date signed	(Month, D	ay, Year)	
İ			1	LA	K	ms	7		-	132	35	5	April 1	7,	2006	
e se	TICK		30. Name and address Daniel	of person who	completed cause of 32. Regi	of death (Item	23a) (Type, I	Print) Point	LRua	d, Su	ite/	07 5	Evensui	lle, r	17 21	666
	Sta Registr		31. Date filed (Month, L	APR 1	32. Regi	ster's Signat	ture #	Acre	(i)							

			1 - For State Registrar	State of Mar	yland / Dep		lealth and N	lental Hygi	-	
ĺ	Physici		Decedent's Name (First, Middle, Last     Robert	ester	Hales			2. Date of Death Month	Day Year	3. Time of Death 11:20 AM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Salisi	Location of Death	- April	4c. County of Death Wicomic	0
	Funeral Director		5. Social Security Number 6. S 220–12–1055 1  Usual Residence of Decedent	XM 2DF	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/31/	(ear) 9. Births Court 1921 Mai	olace (State or Foreign ntry) Cyland
	e Maryland e-f show	ctor	10a. State 10b. County  Maryland Wicomi		oc. City, Town or Lo Salisbury					0d. Inside City Limits 1 Yes 2 No
	h with the	al Dire	10e. Street and Number 4891 Airport Roa	ıd		10f. Zip Code 2180	4	10	g. Citizen of What Cou USA	ntry?
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Items 23a or 28e-f show says injury or other treumatic event, the Maxical Examinar must be maillised at ODCe.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
D-C1717	I within 72 ho lene. r then "natur itte Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed)  College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most of work	ing	Sb. Kind of Business/In	,
yland ,	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Reuben Lester Ha				Ethel			
Mar	alth and 2.27 is must reuma		19a. Informant's Name/Relationship ( Linda Ellis/daug		19b. Maili 429	ng Address (Street a 96 Rambli	and Number or Rur n Rd., Sa	al Route Number, lisbury,	City or Town, State, Zip MD 21804	Code)
baltimore,	Pages 1 annount of He ent: If item arry or othe		20a. Method of Disposition  1 XBurial 2 Cremation 3   4 Donation 5 Other (Specification 2)	Removal from State	20b. Place of Dispo cemetery, cre Wicomic Park	osition (Name of matory or other place O Memoria	1 4/1	5/06	oc. Location - City or To Salisbury,	
Dall	permit. Departr Importe any inju			nesses CFS	~p 2	Name and Address Holloway 501 Snow	Funeral H Hill Rd.,	Salisbu	essional As cy, MD 2180	ssociation 04
and the second	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	plications that caused the one cause on each line.  a. Due to (or as a control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	onsequence of):	ter the mode of dyin	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
08/00,	cate be execute physicien and the burial-trans	dical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	cDue to (or as a c	onsequence of):					
O. Box o	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 { 4 Pregnant at tim	☐Fetal death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
cords, r	uires that signed b	by	Part II. Other significant conditions of	ontributing to death but r	-	inderlying cause give	en in Part I.		cco use contribute to t	
T T	The law requate has been page 2 shou	Completed	DEMENTIA,					24a. Was an autopsy perform	prior to co death?	psy findings available mpletion of cause of
VII	ysiclen is certifi director	o Be	25. Was case referred to medical examiner? 1 Tyes 1 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DOA Othe		h <i>(Check only one)</i> ime 5 ☐ Residen	ce 6 □Other (Specil	y)
VISION OF	To the Hospitel or Attending Physiclen: The law within 24 hours after death. To the Funerel Director After this certificate has completely filled in by the funeral director, page 2	atlon: T	27. Manner of Death  Natural 5 Pending 2 Accident investigation		ear) 28b. Time o	f 28c. Injury Work	/ at	28d. Describe how		
	itel or Attures after de rel Directo	Certification:	3 Suicide 6 Could not be determined	building, etc. (	Specify)			City or Town,		
	ne Hosp 24 hou ne Fune detely fil	edical	29a. Certifier Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of r niner: On the basis of ex and manner stated	ramination and/or in	h occurred at the tim vestigation, in my of	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as s e and place, and due ti	tated. the cause(s)
	Tott Withii Tott	Me	29b. Signature and title of certifier			29c. License	number 63 199		d. Date signed (Month,	Day, Year)
	10%		30. Name and advice s of person who Yogesh Vohra							
91	Sta Registr		31. Date filed (Month, Day, Year) APR 1 4 2	32. Pagistrar's						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day April1 2006 **Physician** 6:52 A M PERRY MILO HOISINGTON II /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**₹** M 2□ F 081-32-9843 90 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r then "naturel", or iteme 23s or 28s-f sho the Madical Examiner must be notified at 1 √ Yes 2 No Washington, DC Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20009 Funeral 2400 16th Street, N.W. # 545 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No
If Yes, Give 1939 -14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 1939 Year or Dates: 1965 ģ 3 Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 U.S. Air Force Pilot & Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Importent: If Itam 27 is marked oth enty intry or other traumatic event ADR. Be Mary Josephine Suing Gregory Hoisington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Perry M Hoisington III (Son) 95 Quarles Rd., Fredericksburg, VA. 22405 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 7/12/06 Arlington, Virginia 9 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Murphy Falls Church Funeral Home 21. Signature of Funeral Service Licensee 1102 W Broad St., Falls Church, Va. 22046 ack 23a. Ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 051 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 2 No 2X No 1 Yes within 24 hours eftar death. To the Funerel Director: After this certifica completely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death 28b. Time of 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital within 24 hours e To the Funerel D Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in a manner. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

8+1 State

1t

ime

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month PR

completed cause of death (Item 23a) (Type, Print) SYUNDA, MI) 9715 A

P (1M, 1)6

32. Segistrar's Signature

Media

10062435

Coster Dr. Lockville, MI)

29d. Date signed (Month, Dey, Year)

2006

			1 - For Stata Registrar	State of M	Maryland		artment rtificate			and M		giene	06	131	,46
	Physici	an	1. Decedent's Name (First, Middle David Parker	, Last) Holt							2. Date of Dea	Day	Year		of Death a M
	/Medic		4a. Facility Name (If not institution,		r)		4b. City,	Town, or	Location o	f Death	April		ty of Deat	7:25 h	- a
	LAdiiii	iei	Montgomery Hos	•		е	Rocks						tgome		
45	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. Ia	-	If Under Months	1 Year Days	If Under 2		8. Date of Birth (Month, Da)	h /, Year)	9. Birt	hplace (State untry) yland	or Foreign
si s	Director		213-23-0575 Usuel Residence of Decedent		30	Yrs.					(Month, Da) Aug. 8,	1975	Maı	ryland	
	yiand you		10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside	City Limits
	e Mar Sa-fal	ctor	Maryland Montg	omery	Silve	er Spr	ing							1 🗌 Ye	s 2 ^N No
	with th	Directo	10e. Street and Number				10f. Zip					10g. Citizen o		untry?	
	eath v	Funeral	9039 Sligo Cr	12. Was Deceder				0901	spanic Orio	nin? (Soe	acify Yes or No-		USA	rican Indian,	
2-0030	permit. Pages 1 and 2 should be filed within 72 hours affer death with the Maryland Department of Heath and Mental Hygiene. Department: If them 27 is marked other than "natural", or iteme 23a or 28a-f ahow any injury or other traumatic event, the Moulcal Examinar must be multified at once.	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Force	s? <b>X</b> No		f Yes, spec		Specity:	, Puerto	ecify Yes <i>o</i> r No- Rican, etc.)		lack, White	e, etc.	
2	natur	Completed	15. Decedent' (Specify only highes			(Give	dent's Usua kind of wor	k done a	lurina most	of worki	ing	16b. Kind of	Business/	Industry	
7 7	withir than	dmo	Elementary/Secondary (0-12)	College (1-4a	r 5+)		oo not us Repi			ve		Appl	iance	es	
and	other vent,	BeC	17. Father's Name (First, Middle, L	ast)			L				(First, Middle,	~ ~			
ylar	12 should be filed within 7: h and Mental Hygiene. 7 is marked other than *n fraumatic event, the Medi	To E	Robert Clarence	e Holt						Parm	a Westb	ury Tu	ten		
e, Mar	and 2 sh salth and n 27 la m iar traum		19a. Informant's Name/Relationsh Robert Clarence			1220	Kathr	yn l			ver Spr				
	Pages 1 nent of H ant: If Iter ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		B C81	ace of Dispo metery, cren Creek	natory or of	her place	9) A	pril	0ate . 17, 06	20c. Location			
Dall	permit. Departi Import any inj		21. Signature of Funeral Service L	icensee S	Dec						Funeral , W, Si			g, MD	20901
, F	hysician /Medical		23a. Part1. Enter the disease, or shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death)	Ewings	line.	ma	er the mode	of dying	g, such as	cardiac c	or respiratory ari	rest,		Approxim Interval B Onset and	etween
學	Examiner		Sequentially list conditions	b	is a conseque	ence ory.									
	cuted br ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events	Due to (or a	is a conseque	ence of):									
0000	cate be executed by sician and the burial-transit	dical Ex	resulting in death) Last	Due to (or a	is a conseque	ence of):									
Ö :	ding ph	0	IF FEMALE:	220 If you guttoom		*									aler all the little of the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and the latest dealer and
O. DOX	ine law requires mat the death certificate tite has been signed by the attending phys bage 2 should be detached for use as the	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal o	death 3□	Ectopic pre Other (spe						ate of del Month	Day	Year
ŗ,	s mar ned by e deta	by Ph	Part II. Other significant condition	ns contributing to death	but not resul	ting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to	bacco use co	ntribute to	the cause of	death?
cords,	equire en sig ould b										1 □ Y	es 21 No	3 🗆 Pr	obably 4	]Unknown
	the law re ate has be page 2 sho	Completed									24a. Was a autop perfor 1 Yes	sy med?	were au prior to death?	topsy finding completion of	s available cause of
2	rnysician: rthis certifica ral director,	Be	25. Was case reterred to medical examiner?	Hospital:				Otho	_		Check only or				
5	To the frozents of Attending Prysician: The law within 24 hours after the forest offer closes. After this certificate has completely filled in by the funeral director, page 2.	ation: To	1 ☐ Yes ☒☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of Ir (Month, L	jury 2	R/Outpatien 28b. Time of Injury		Bc. Injury Work	4 🗆 1401	1	me 5 Resid 28d. Describe h			Mosp:	ice
	al or Attending s after death. Il Director: After id in by the fune	ertific	3 Suicide 6 Could n 4 Homicide determin	ned 286. Place of I	njury - At hon etc. (Specify)		eet, factory,	office			28f. Location (S City or Tow		nber or Ru	ral Route Nu	mber,
	lo the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical C	29a. Certifier (Check only one)  1 ☑ Certifying 2 ☐ Medical E	Physician: To the best xaminar: On the basis and manner	of examination	rledge, death on and/or inv	occurred a restigation,	it the tim in my op	e, date and inion, deat	d place, a	and due to the c	ause(s) and n late and place	nanner as e, and due	stated. to the cause	(s)
i	within To th	M	29b. Signature and title of certifier				29c.	License				9d. Date sign			
				~ 1	20			D3	5635		A	pril l	ے, کا	,00	
	6		30. Name and address of person w Joseph Kaplan,	•				Rock	/ille	, MD	20855				
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 4	32 Panis	trar's Signatu	11.0									

DHMH 17 Rev 1/2001

06-02580

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Keith A. Hickman		Segistrar	tate of Maryla		artment of <i>rtificate of</i>		d Mental H		200	6 33		
Physician Medical Examine	1/	1. Decedent's Name (First, Midd Keith		Hic	kman			2. Date of Deat Month April 16, 2	Day Year	3. Time of Death 1200 hrs		
		4a. Facility Name (if not instituti 9302 Frostburg Way	on, give street and no	imber)		Montgomery		th	4c. County of Dea Montgomery	th		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	last birthday)	If Under 1 Year Months Days			th(MM/DD/YYYY) 9 B Fore	ign		
Director		170-48-7992 Usual Residence of Decedent	1 M 2 F	4	Yrs	Mienans   Baye	7100.0		21,1957 ^c	ountry) PA		
any	- 1-	10a. State 10b. County		10c. City	, Town or Locati	on				10d Inside City Limits		
ith the Maryland 23a or 28a-f show notified at once.	គ្ន	MD. Mont	tgomery	R	lockvill	e 10f. Zip Code	_	Laz	0- 04	1 Yes 2 X No		
the Maryland a or 28a-f sh		4525 Muncaster	Mill Dog	J		20853	1		Og. Citizen of What Co United Sta	•		
with t ms 23a be not	<u> </u>	11. Marital Status	12. Was Dec	edent Ever in U			panic Origin? (	Specify Yes or No-		rican Indian, Black,		
er death	Funeral	1 Never Married 2 N 3 Widowed 4 X Di	1 Yes	2 X No		Yes 2 X No		io Ricari, etc.)		ite		
ours aft atural" (amine	<u>a</u> -	15. Decedent's Education (Spe	or Dates:		16a. Deceden	t's Usual Occupationst of working life.	on (Give kind of		16b. Kind of Business			
36 in 72 ha hau "in lical Ex	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)		J		etired)	71	7		
5-0036 led within 7 Hygiene. to ther than	탕	12 17. Father's Name (First, Middle	e, Last)		ET	ectriciar 1		ne (First, Middle, M	Electri Maiden Surname)	.caı		
and 2 should be filed within 72 hours after feath and Montal Hygiers in an inatural", traumatic event, the Medical Examiner.	e L	Robert 19a. Informant's Name/Relation		Hick		Address (Chart		Emma	Kov nber, City or Town, Stat	acs		
MD 2 d 2 shoul th and N n 27 is m umatic	-	Nicholas Hickm				,			k, Maryland			
re, rand Fleatificen	II.	20a. Method of Disposition  1 Burial 2 X Crematio				ition (Name of cem		Date	20c. Location - City o			
timo t. Page tment ortant:	Metropolitan Crematory 4/22/2006 Alexandria											
Ba permir Depar Import	Signature of Funeral Service Interest Park Dr., Gaithersburg, I Physician  22. Name and Address of Facility DeVol Funeral Home  10. East Deer Park Dr., Gaithersburg, I Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause	r complications that c e on each line.	aused the death	. Do not enter th	ne mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Between Onset and		
xaminer		Immediate Cause (Final disease or condition resulting in death)	a <u>Narroti</u>	s (Fentar	nyl and To	camadol) ir	texication	on and coes	nine use	Death		
		Sequentially list conditions,	b									
led Insit	<u> </u>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C	consequence o								
cuted ind transit		events resulting in death) Last	Due to (or as a	consequence o								
Records, P.O. Box 68760,  The law requires that the death certificate be executed care has been signed by the attending physician and page 2 should be detached for use as the burial - trans	cian/imedical	X UNPENDED	AMENDED			28a-f,perME	E,g855,5/	1/06 TT				
68760, certificate bo riding physic se as the bur		F FEMALE: 3b. Was decedent pregnant in t past 12 months?	he 1 Live		₂ Fe	al death 3	Ectopic pregr	nancy	23d Date of delive Month	ry Day <b>Y</b> ear		
Box 6876 e death certificate the attending phy ed for use as the	เด เ	1 Yes 2 No 9 Ur		nant at time of de own	eath 5 Oth	ner (Specify)						
O. Bo		Part II. Other significant condi	tions contributing to	o death but not r	resulting in the u	nderlying cause gi	iven in Part I.	23e. Did to	bacco use contribute to	the cause of death?		
cords, P.O. law requires that the has been signed by 2 should be detach	led by	Dilated hypert	ensive ather	roscleroti	ic cardio	vascular di	sease	1 Yes - 24a. Was a	2 No 3 Pro	bably 4  Unknown  utopsy findings available		
of Vital Records,  ng Physician: The law requir  ther this certificate has been a  meral director, page 2 should b	Completed		<u></u>					autops	sy prior to med? death?	completion of cause of		
		25. Was case referred to medical	ai			26 Place	of Death (Checl	1 Yes 2 k only one)	2 No 1 Y	es 2 No		
i of Vital Recing Physician: The After this certificate uneral director, page	<u> </u>	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient				Residence 6 🗸 Othe	er Scene		
nding Pater		27. Manner of Death  1 Natural 5 Pen	y at Work? es 2 χ No	28d. Describe h	now injury occurred							
Solution (Street and Number or Rural or Town, State) 3 Description of the determined of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat												
Div Hospital of 24 hours af Funeral D	를 기	4 Homicide dete		House				or Town, St ntgamery	y Village, MD	ourg way		
	<u>.</u>			of examination a					e(s) and manner as sta and place, and due to t			
2	Me	29b. Signature and title of certifi				29c, License			29d. Date signed (Mo	onth, Day, Year)		
2		Sam	a who a complete d	M P	220)	O.C.N	Л. E.		April 17, 2006	<del></del> -		
			sistant Medical			treet, Baltimo	re, MD 2120	01				
Stat Registra	te ar	31. Date filed (Morta Der, Yzer)	5 2006 32	gistrar's Signati	to April	de						

DHMH 17 Rev 1/2001

State Registrar Marcia Lee Will,

M.D.

1ª3 2006

2 degistrar's Signatur

7525 Greenway Center Drive #205; Greenbelt, Maryland 20770

			1 - For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artme rtifica	ent of H a <i>te of i</i>	lealth Deatl	and N	/lental		ene	06	31	149
	Dhysisi		1. Decedent's Name (First, Midd	le, Last)							2. Date Mont	of Death	Day	Year	3. Time	of Death
	Physici /Medio		Herbert Wil	liam 1	Hall						1		0, 20		3:00	рм
	Examir		4a. Facility Name (If not institution	n, give street and r	number)		4b. C	ity, Town, or	Location	of Death			4c. Cou	nty of Death	1	
			2921 N. Leis	ure World	Blvd.	Apt. 401	S	ilver	Spr	ing			N	Montgo	mery	
П	Funeral		5. Social Security Number	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs	. last birthday)	If Un Monti	der 1 Year ns Days	If Unde	r 24 Hrs. Min.	8. Date	of Birth h, Day, Y	'ear)	9. Birth	nplace (State	or Foreign
ш	Director		578-24-6855	123 M 2 1	80	Yrs.					Aug.		1925			on, DC
	and		Usual Residence of Decedent  10a. State 10b. Count	,	10c. C	ity, Town or Lo	cation								10d. Inside	City Limits
	Mary fehc	ō	Maryland Mont	gomery	Si	lver Sp	orin	α								es 21 No
	288 288	Director	10e. Street and Number				_	Zip Code				100	Citizen	of What Cor	intry?	
	Sa or	<u> </u>	2921 N. Leisur	e World F	Blvd. An	+. 401		209	06				USA	5. W. Lat. 00.	y .	
	death with the Maryland ms 23s or 28s-f ehow rmast be rediffed at	Funerai	11. Marital Status	12. Was De	ecedent Ever in l	J.S. 13. V	Was De	cedent of H	ispanic O	rigin? (Sp	ecify Yes	or No-		Race - Amer	ican Indian.	
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-1 show emportant: If item 27 is marked other than "natural; or items 13a or 28a-1 show employinty or other treumatic event, the Medical Examinar must be notified at once.		1 ☐ Never Married 2 ☐ Mai	ned 1 X Yes	Forces? s 2 ☐ No Bive		fYes, s	pecify Cuba 2 X No	n, Mexica Specifi	an, Puerto	Rican, etc	;.)	В	Black, White	, etc.	
3-003p	urai',	d by	3 ☐ Widowed 4 1 Divorce	Year or	Dates: 1945	-47		202110	эрвын	··			Зре	c <i>ify</i> Whit	e 	
<u></u>	nati	Completed	15. Deceder (Specify only highe	nt's Education ist grade complete	d)	(Give	kind of	sual Occupa work done o	durina ma	st of work	ing	16	b. Kind of	Business/I	ndustry	
7	han.	ш	Elementary/Secondary (0-12)	College	(1-4or 5+)			Tuse retired	)							
7	Hygie Hygie Ther nt, m		12 17. Father's Name (First, Middle,	(act)		Bric	кта	yer	10 Moth	anda Nam	e (First, M	intella 8 da		orer		
yland	12 should be filed v n and Mental Hygie 18 marked other reumatic event, In	Be	Herbert Will								aine			ame/		
2	houk d Me mark matic	၉	19a. Informant's Name/Relation:			10h Mailin	a Addr	nes (Stroot						vn, State, Z	(- C- f-)	
20	d2s than t7 is:		Diana Malamen		er		-						•		208 <b>7</b> 9	3
บ์	1 an Heal em 2 ither		20a. Method of Disposition			Place of Dispo	sition (	Vame of	T	-	Date	-		n - City or T		
Ē	Pages nent of I ant: If its		1 ☐ Burial 2 🖾 Cremation		m State	cemetery, cren	natory o	or other plac		Apri:	1 12 006				Virgi	nin
paltimo	artme ortan injury		4 □ Donation 5 □ Other (\$ 21. Signature_of Funeral Service		120							-			VIIgi	шта
Ö	Per Impo		1 Benin 2	8:4:		5	ran 00	and Addrs Cis J's Univer	rsity	ľlins / Blv	Fune	eral Sil	Home Lver	Inc Sprin	g. MD	20901
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	t caused the dea									-	Approxim- Interval B	
	Physician		Immediate Cause (Final												Onset and	d Death
ı	/Medical		disease or condition resulting in death)		ebral V		Ac	cident	<u> </u>							
	Examiner				ertensi										Years	5
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	o (or as a conse	querice of).			-							
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events	c												
Ş	e exe ian ai ırial-t	EX	resulting in death) Last	Due to	o (or as a conse	quence of);										
	cate be executed physician and the burial-transit	dicai		d	_											
		(D)	IF FEMALE:	1												
Š	ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 Pet	al death 3 🗆	Ectopic	pregnancy						Date of deliv	,	V
5	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pre	gnant at time of a known	death 5□	Other	(specify)					'	Month	Day	Year
	hat thid by		Part II. Other significant conditi	One contributing to	dooth but not ro	oulting in the	edo ab sim		n in One		020	Did taba				
Ŝ	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	by	Takin. Other significant conditi	ons contributing to	dean but not re	sulling in the un	oenyin	g cause give	n in Pan	1.			ccousecc 2. Z¥No		the cause of bably 4	
5	w require been si should I	etec										-	2 (3440		bubly 4	JOHRHOWH
ב	has t	Completed										Was an autopsy		prior to co	opsy finding: ompletion of	s available cause of
	: Th	Ö,										es 21X		death? 1 ☐ Yes	2□ No	
=	ician Sertifi ector	Be	25. Was case referred to medica examiner?	t Hospital:				0			h (Check o					
5	Phys this al dir	٩	1 X Yes 2 □ No 27. Manner of Death			ER/Outpatient	3 🗆		4 🗆 14					ther (Speci	fy)	
=	a fe	0	1 X Natural 5 ☐ Pendir	ng (Mo	e of Injury onth, Day Year)	28b. Time of Injury		28c. Injury Work			28d. Desc	ribe how	injury occ	urred		
2	r Attending er death. rsctor: After by the fune	icat	2 Accident investi 3 Suicide 6 Could	not be	no of laive. At h	12	M		/es 2 [		006 1	(C4				
5	after after Dirsc	Certification:	4 Homicide determ	nined 200. Flat buil	ce of Injury - At h ding, etc. (Speci	fy)	ет, таст	ory, office			City o	r Town, S	state)	n <i>oer or Hur</i>	al Route Nu	mber,
-	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Co	(Crieck Only 2 Medical	ng Physician: To the Examiner: On the	pasis of examina	owledge, death ation and/or inv	occurr	ed at the tim on, in my op	e, date a inion, de	nd place, ath occurr	and due to	the caus	se(s) and a	manner as s	stated. o the cause	(s)
	thin 2 this mple	Med	29b. Signature and title of destition	and ma	nner stated.			29c. License		_				ned (Month,	. ,	
	E 3 E 8			AL	all		1	D532						1, 200		
			. Se	nge 1	77											
,	5+1		30. Name and address of person Peter Stengel,		use of death (Ite 525 Gree			ar Dri	Ve	π4	Grace	hol+	ME	2077	)	
	-01			32	Resistrar's Sign	ature			. v e ,	1- <b>T</b> ,	or eeu	ne I C	, MD	20110	,	
	Sta Registra		31. Date filed (Month, App Rear	3 2006	Masur	K 1	Logo	Val.								

			1 - For State Registrar	State of M	Iarylan		artment rtificate			nd M		iene	06	345	jÛ
ı	Physici	an	1. Decedent's Name (First, Middle, Last	)							2. Date of Deat Month	th Day	Yea	3. Time of I	Death
	/Medi		Annie Virginia Ho				,				April 4		006	6:20	м е
	Examir	ner	4a. Facility Name (If not institution, give	street and number	)		4b. City, 7	Fown, or	Location of	Death	-	4c. (	County of De		
			Holy Cross Rehab a 5. Social Security Number 6. Se.			nter last birthday)	Bur If Under		ville If Under 2		0.0	J		gomery	
	Funeral Director			M 257 /	89	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 12/16/1	916	9. 5	Birthplace (State or Country) PA	Foreign
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City	. 1 7—11
	Maryli f sho	ō				,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		_ 1						11√∑Yes	
	28a-	Director	MD Prince Ge  10e. Street and Number	orge's			Laur:				1	0a. Citiz	en of What	11	
	h with		1011 Harrison Dri	170				201	707				USA	<b>,</b> ·	
	deat ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	.S. 13.	Was Deced			in? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Ar	merican Indian,	
90	or ite		1 Never Married 2 Married	1 ☐ Yes 2 X			1  Yes 2		Specify:	rueito i	nicari, etc.)		Black, Wi Specify:	nite, etc.	
Ö	72 hours after death with the Maryland hatural', or items 23a or 28a-f show Jical Everoll wit neat be neithed at	d by	3 XWidowed 4 □ Divorced	Year or Dates:										White	
21215-0036	in 72 " na'	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	dent's Usual kind of worl DO NOT use	l Occupa k done di e retired)	tion uring most	of workir	ng	16b. Kin	d of Busines	ss/Industry	
212	d with giene, ir thai	шо	Elementary/Secondary (0-12)	College (1-4or	5+)		re Pr					Self	-emp1	.oved	
	e file al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, Last)							's Name	(First, Middle, M			2	
ylaı	Menta Menta Brked Brice	To	Harry Mc Creary						Mak	el E	Bender				
Maryland	2 sho and is m		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a	nd Number	or Rura.	l Route Number,	City or	Town, State	, Zip Code)	
	1 and Health sm 27 ther t		Deborah Goldsboroug	jh/Daught	er	7737	Fairg	reen	Road		mdalk,			T 0	
nor	ages nt of h t: If ite		1 🎖 Burial 2 □ Cremation 3 □ F	emoval from State	, 0	emetery, crer	natory or oth	her place	´ 1					or Town, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Event in and be prufficed at ance.		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	96	S.	Memori	Lal Gd			7/20			irk, M		
Ba	permi Depa Impo any ir		.C. Worr							Ray	mond-Wo		F.H.,	P.A.	
	*		23a. Part1. Enter the disease, or compl. shock, or heart failure. List only or	cations that cause	d the death		D_Box er the mode					9754 est,		Approximate	
	Physician		Immediate Cause (Final disease or condition			A . A .								Onset and De	ath
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):									
	Examiner	_	Sequentially list conditions, if any, leading to immediate			-									
	pe tist	nine	if any, leading to immediate cause. Enter Underlying Cause (Disasse or injury	Due to (or as	a consequ	uence of):									
	execut and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):									
8760,	cate be executed only sician and the burial-transit														
9	tificat ng phy as th	Physiclan/Medlcal		•											
Вох	death certifica attending ph d for use as t	an/N	230. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pre	anancv				23	d. Date of d		
0	ne dea the at hed fo	sicl	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant a 9□Unknown			Other (spe					I	Month	Day Ye	ar
م.	that the di ed by the detached		Part II. Other significant conditions cor	tributing to death t	out not resu	ulting in the ur	nderhing ca	use civer	in Part I		23e Did tob	acco us	e contributo	to the cause of dea	th2
ds,	The law requires that the death certific tle has been signed by the attending p page 2 should be detached for use as	d by	Tall in a mar and market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a market a mar	windting to death t	out not rest	and an the di	idenying ca	use giver	riii raitt.		1 □ Ye			Probably 4 Uni	
Record	w requ	lete									24a. Was ar			autopsy findings av	
Re	The lav	ompleted								_	autopsy	/	prior to death?	completion of cau	se of
Vital		e C	25. Was case referred to medical					-	26 Place o	of Death	1 Yes 2	No	1 🗆 Ye	s 2 No	
<u>&gt;</u>	Physici this cer al direc	ToB	examiner? 1 Yes 2 No	ospital: 1 🔲 Inpati	ent 2 🗆 1	ER/Outpatien	1 3 DOA	Other			e 5 ☐ Reside		Other (Sp	ecify)	
0	ng Pł		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time of Injury	28	c. Injury a			8d. Describe ho				
S	tendi eath. for: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 No						
Division of	il or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	4 Homicide determined	28e. Place of In building, e	jury - At ho tc. <i>(Specify</i>	me, farm, stre /)	et, factory,	office		2	8f. Location (Str. City or Town,	eet and State)	Number or F	Rural Route Numbe	r,
_	Hospital or Atten 14 hours after deat Funeral Director: tely filled in by the		29a. Certifier 1 Certifying Phys	ician: To the heet	of my know	wledge death	occurred o	the time	date and	place o	nd due to the se	use(s) -	nd manner	as stated	
	Hos Fur h	edical	(Check only 2 Medical Examin	ner: On the basis of and manner st	if examinat	ion and/or inv	estigation, i	n my opi	nion, death	occurre	d at the time, da	te and p	lace, and du	ue to the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier	- A A		Α.	29c.	License	number		29	d. Date	signed (Mor	nth, Day, Year)	
			Mercia	Herld	mei	ih, n	C Ci	> みな	534	4		4	504	0	
	10		30. Name and address of person who co	mpleted cause of o	death (Item	23a) (Type, I	Print)	0	^	0	1 0				
	Ψ		Marcia Goldn		10 1	5020	Sha	dy	Onn	CK	a, 160.	cle	lille	, MO 20	750
	Sta Registr	- 5	31. Date filed (Month, Day, Year) APR 0 6	2005 ► 2											

			For State Registrar		State o	f Maryla	nd / Depa <i>Cei</i>	rtment <i>tificate</i>			and Me		iene	06	13451
	Physici /Medi		Decedent's Name (First     GERTRUDE C		*	ZZ						2. Date of Deat PRIL	1gay	2966	3. Time of Death 9:20 P _M
£.	Examir		4a. Facility Name (If not in FREDERICK					4b. City, FREI	Town, or DERIC	Location o	of Death			nty of Death	1
19 m2	Funeral Director		5. Social Security Number 154–28–5156	6. S	ex □M 2∏xF	7. Age (In yrs 70	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day,		Coun	**
	pu .		Usuaf Residence of Deced	ent		100.0	b. Town and					OV - 27 - 1			sylvania
	shov	5		ederic	1-		ity, Town or Lo iddleto							10	od. tnside City Limits 1√2 Yes 2 □ No
	28a-f	Director	10e. Street and Number		. K	M		W11	Code			11	Da Citizan	of What Coun	
	3a or	D	1 Sanaz Cou	ct					1769						try r
	death	ner	11. Marital Status		12. Was Dece		J.S. 13. V				gin? (Speci	fy Yes or No- can, etc.)	14. R	SA lace - America	
36	within 72 hours after death with the Maryland ene. then "natural", or liems 23e or 28e-f show ta Medical Examinar musi Le notified at	Completed by Funeral	1 Never Married 2	-	Armed Fo 1 Tes If Yes, Giv Year or Da	² XNo	1	Yes, speci		specify:	, Риепо ні	can, etc.)	Spec	llack, White, e	ite
21215-0036	2 hou	ted	15. De	cedent's Ed	lucation	1.63.	16a. Deced	ent's Usual	l Occupat	tion			16b. Kind of	Business/Ind	
215	thin 7.	ple	(Specify only Elementary/Secondary (		de completed) College (1	-4or 5+)					of working				
7	filed wi Hygien other th	Con			5±	•	Comp	uter						cation	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show apprintury or other treumatic event, the Medical Examinat must be notified at ance.	To Be	17. Father's Name (First, M Henry	diddle, Last) Cla		Conge	r, III			-	r's Name (I nma	First, Middle, N Gertru		,	ock
Jan	2 sho		19a. Informant's Name/Re									Route Number,			Code)
	1 and Health am 27 ther tr		John Horowit  20a. Method of Disposition	z/Hus	band	20h	1 San			Mid	ldleto Dat	own, MD			Charles Charles
altimore,	Pages nent of P ant: If itu	1	1 ☐ Burial 2 ⚠ Crem 4 ☐ Donation 5 ☐ O			State	cemetery, crem	atory or oth	her place	1				n - City or Tov	
<u></u>	permit. P Departme Importan any injur.		21. Signature of Fun-ral S			Fre	ederick	Crem Name and	ator Address	y 4	+/13/2	2006 Fuffer F	reder	ick, M	) DA
m	Depa Impo Impo any it	1	D. C. T.	onto	Gr		16	21 Op	ossu	mtown	ı Pike	Fred	unera. erick	.MD 211	702
			23a. Part1. Enter the dise shock, or beart failure	ase, or comp a. List only	plications that ca one cause on ea	aused the dea	th. Do not ente	r the mode	of dying	such as o	cardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	-	a	Jou	te n	140	COY	dia	Lin	Frac	tion		1 Day
t,a)	Examiner				Due to (	or alera consec	quence of):								
8	n =	ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying		b. Due to (	or as a consec	tuence of).	V							
	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c										
8760,	be ex ician burial	aiE	and the second second		Due to (	or as a consec	quence of):								
	ficate physics from	edicai			d										
Box	death certifi e attending   id for use as	N/M	IF FEMALE: 23b. Was decedent pregna	int	23c. If yes, out								23d. D	Date of deliver	v
O. B	0 0	Physician/Me	in the past 12 months 1 Yes 2 No 9 Unknown	?		rth 2 ☐ Feta ant at time of c wn		Ectopic pre Other (spe					N	Month [	Day Year
J.	res that the igned by be detact		Part If. Other significant co	onditions co	entributing to de	ath but not res	sulting in the un	derlying car	use giver	in Part I.		23e. Did toba	acco use co	ntribute to the	cause of death?
Vital Records,	The law requires that the te has been signed by th vage 2 should be detache	ed by	Ovas	ian	Ca	nce/						1 ☐ Yes	s 2 No	3 Proba	bly 4 Unknown
ဝ၁	law re	Completed		,		,						24a. Was an		. Were autop	sy findings available
		Com										autopsy perform		prior to com death? 1 \( \text{Yes} \) 2	pletion of cause of
Ξ	sicien: Th certificate rector, pag	Be (	25. Was case referred to mexaminer?				1				of Death (C	Check only one			
ō	Phys this aldii	7	1 Yes 2 No		Hospital: 1 ☐ Ir 28a. Date o		ER/Outpatient	3 DOA		4 🗆 Nur:		5 Resider			
0	ding I th. : After funer	tion	1 ☑Natural 5 ☐ I	ending nvestigation	(Month	, Day Year)	28b. Time of Injury	м 28	c. Injury a Work? 1 □ Ye	at es 2.⊡N		f. Describe how	v injury occi	urred	
DIVISION	To the Hospitel or Attanding within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 □ 0	Could not be letermined	286. Place	of Injury - At hi g, etc. (Specif	ome, farm, stre y)	et, factory,			-	Location (Stre City or Town,	eet and Nun State)	nber or Rural	Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier 12 Ce (Check only one)	rtifying Phy	vsician: To the liner: On the ba	sis of examina	wledge, death	occurred at	t the time	, date and nion, death	place, and	I due to the cau at the time, dai	use(s) and n	nanner as sta	ted.
	To the within 2 To the complet	Med	29b. Signature and title of o		and mann	ei Stateu.			License					ned (Month, D	
	Fs⊢ő			, (	7-1	W:			N	516	1. 2		A. 1	20.0	, , , , , , , , , , , , , , , , , , , ,
	10-		30. Name and address of p	erson who c	ompleted cause	of death (Iten	n 23a) (Type, P	rint)	0	110	7 >		7 12	- V D	<u>-</u>
	/ /		65 C	Tho	mas	11	inons en	n I	2		for	dent	KN	10 0	1702
	Sta Registr		31. Date filed (Month, Day,		2006	istrar's Signa	iture .	medi)	,	,					

			1 - For State Registrar	State	of Mary	land / Dep <i>Ce</i>		ent of H ate of I			1ental Hy	/gier Reg. N	UU	6	13452
	Planelal		1. Decedent's Name (First, Midd	le, Last)							2. Date of D		Day	V	3. Time of Death
ı	Physici /Media		Elizabeth	Regina	H	ewitt					April			Year 5	12:05 p.\m
	Examir	er	4a. Facility Name (If not institution	n, give street and	number)		4b. C	ity, Town, o	Location	of Death		4	c. County	y of Death	
ģ		達	Hermitage at S	+					omons	_			Cal	lvert	
	Funeral Director		5. Social Security Number 217–46–6739	6. Sex 1 ☐ M 2 ☑		yrs. last birthday, Yrs.	Monti	der 1 Year ns Days	If Under Hours	Min.	8. Date of Bi (Month, D Dec . 27	rth ay, Yea 1	912	9. Birth Cou Mary	place (State or Foreign ntry) 'land
	and and		Usual Residence of Decedent  10a. State 10b. County	,	100	c. City, Town or Le	ocation								10d. Inside City Limits
	Mary!	ō	Marry 1 and Car					o 1 oma							1 ☐ Yes 2 🕅 No
	28a	Je C	Maryland Cal	Lvert				Solomo Zip Code	nis			100.0	Citizen of	What Cou	ntn/2
	3a or	<u></u>	13325 Dowell H	Road			1.0	206	88					Stat	
	ms 2	era	11. Marital Status	12. Was D	ecedent Ever	in U.S. 13.	Was De	cedent of H	ispanic Ori	igin? (Spe	ecify Yes or N				can Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f show say injury or other traumatic event, the Medical Examiner must be natified at once.	by Funeral Director	1 Never Married 2 Mar	nied 1 🗆 Ye	I Forces? es 2X No Give or Dates:		If Yes, s	pecify Cuba 2 XNo	n', Mexicar Specify:	n, Puerto	Rican, etc.)		Bla	ck, White, y: Whi	etc.
Ö	2 ho	Completed		nt's Education				sual Occupa				16b.	Kind of B	usiness/lr	dustry
215	thin 7	nple.	(Specify only higher Elementary/Secondary (0-12)		e (1-4or 5+)	life.	DO NO	work done d use retired	during mos )	t of worki	ng				
7	od wi	Son	10				Home	maker					Ov	vn Ho	me
nd	at Hy	Be (	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	e (First, Middle	, Maide	en Suman	ne)	
<u>  X</u>	Ment Ment arke	ပ	Benjamin Franc	cis Redma	an				Ar	nn El	lizabet	h B	ean		
lar	2 sho and lam sum		19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Addr	ess (Street a	and Numbe	er or Rura	al Route Numb	er, City	or Town,	State, Zij	Code)
≥ ~	and ealth m 27		Mary R. Ott /	Daughter					k Way		11ywoo	d, 1	Mary1	Land	20636
Baltimore,	or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 Removal fro		Ob. Place of Dispo cemetery, crei	sition (f matory o	lame of r other plac	θ)		ate	20c.	Location -	City or To	own, State
Ē	Pag ment ant: lury		4 ☐ Donation 5 ☐ Other (5		do S	t. Georg					-2006				Maryland
Sali	Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Depart		21. Signature of Funeral Service	Licensee	-	in 2	2. Name	and Addres	s of Facilit	^y Brir	sfield	Fu	neral	L Hom	e, P.A.
	0 D E ● 0		Kyle S.		M012	06 22	955	Holly	wood	Road	l, Leon	ard			20650-0279
25	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause of	at coused the on each line.						ME DE DOSE	ırrest,			Approximate Interval Between Onset and Death
2	/Medical Examiner		resulting in death)	Due		nsequence of):			) 7	13/1	Coch				yeras=
100		_	Sequentially list conditions,	b	COLOU		1205	TEN	7	ノンジ	シルフヒ				
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due	to (or as a cor	nsequence of):									
	and and III-trar	хап	that initiated events resulting in death) Last	c	to (or as a cor	Sequence of):							_		
09	icate be executed physicien and s the burial-transit				(										
38760,	icate phys s the	dicai		d											
Box (	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	/W	IF FEMALE: 23b. Was decedent pregnant	23c. Il yes,	outcome of pre	egnancy							23d Dai	te of delive	200
ă	death a atte	Physician/M	in the past 12 months?		re birth 2 □I egnant at time			pregnancy (specify)						nth	Day Year
P. O.	by the	hys	9 Unknown	9□ Un	known										
	res that the de signed by the a be detached f	by P	Part II. Other significant conditi	ons contributing to	o death but not	t resulting in the u	nderlyin	cause give	n in Part I.		23e. Did t	obacco	use cont	ribute to th	ne cause of death?
Records,	w require been sig should b										1 🗆	Yes 2	2 □ No	3 Prob	ably 4 Junknown
ပ္တ	s bet	Completed									24a. Was	an	24b. \	Were auto	psy findings available
Ä	The lav	E O										rmed?	(	death?	psy findings available mpletion of cause of
a	icien: Th certificate rector, pag	0	25. Was case referred to medica	1			1702-1		26 Place	of Death	(Check only of	2 X N	0	I □ Yes	2.00 No
>	\$ 0 D	ToB	examiner? 1 □ Yes 2⊠No	Hospital: 1	☐ Inpatient	2 ER/Outpatien	nt 3□	OOA Othe			ne 5 Resi		6 □Oth	er /Snecit	v)
0	9 Pl		27. Manner of Death		ite of Injury Ionth, Day Yea	28b. Time of Injury	,	28c. Injury Work			28d. Describe				77
Ö	Attending or death. ector: After by the fune	atic	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	onin, buy rou	a) Injury	М		es 2 1	Vo					
Division of Vital	al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined   286. Pla	ace of Injury - / Ilding, etc. (Sp	At home, farm, str pecify)	eet, fact	ory, office		2	28f. Location (. City or To			er or Rura	l Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	edical (	29a. Certifier (Check only one)  Certifyir  2 Medical	ng Physician: To Examiner: On the and m	the best of my e basis of exan anner stated.	knowledge, death nination and/or inv	occurre vestigati	ed at the tim on, in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s	s) and ma	inner as st and due to	ated. the cause(s)
	To th To th Somp	Me	29b. Signature and title of certifie	r			2	9c. License	number			29d. D	ate signed	d (Month,	Day, Year)
								02	96	エフ		L	1/ 14	1110	
		-	30. Name and address of persen	who completed ca	ause of death (	(Item 23a) (Type	Print)	U 04	, , ,				/ //		
			Charles A. Jud	,			,	d, Pr	ince	Fred	erick.	Mar	ylan	d 20	678
1	Sta		31. Date filed (Month, Day, Year)	200	. Registrar's S	ignature							,		
-	Registra	3r	APR 17	2006	Table 1	K does									

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death John William Hollett, Jr.

2006 13453

				- For State Registrar		entificate d	or Dealir			eg No.	-1
led		hysicia Exami	an/ ner	1. Decedent's Name (First, Middle,Last)  John Will:		llett,			2. Date of Dea Month April 15, 2	Day Year 2006	3. Time of Death 1535 hrs
	7.5			4a. Facility Name (if not institution, give s Civista Medical Center	treet and number)		4b. City, Tow La Plata	n, or Location o		4c. County of Dea	
		neral ector			7. Age (In yrs	s. last birthday) Y	If Under 1 Months	Year If Under Days Hours		25,1947 For	Birthplace (State or eign Country)Virginia
	73	now any E.		Usual Residence of Decedent  10a. State 10b. County  Maryland Charles		ity. Town or Loc Charlott					10d. Inside City Limits  1 Yes 2 X No
	Marylan	23a or 28a-f show notified at once.	Director	10e. Street and Number			10f. Zip Co			Og. Citizen of What Co	
	with the	is 23a or e notifie		7630 Arborview Dr:	2. Was Decedent Ever in		Vas Decedent		gin? ( Specify Yes or No Puerto Rican, etc.)	U S A	erican Indian, Black,
	, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	ul", or iten ner must b	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced If	Armed Forces?  1 Yes 2 No Yes, Give Year r Dates:	1	Yes 2X	No specify:		Specify:	White
	2 hours	"natura I Exami		15. Decedent's Education (Specify only Elementary/Secondary (0-12)	highest grade completed College (1-4 or 5+)			cupation (Give ig life. DO NOT	kind of work done use retired)	16b. Kind of Busines	
	0036 within 7	Hygiene. other than ' the Medical	Completed	17. Father's Name (First, Middle, Last)	5+	Ci	vil En		's Name (First, Middle,		Corporation
	215- be filed	ntal Hyg rked ofl ent, the	å	John William	Hollett			Barb		•	otree
	AD 21 2 should	and Me 27 is ma matic ev	ြို	19a. Informant's Name/Relationship (Type Janet W. Hollett/					nber or Rural Route Nuive, Charle	otte Hall,	MD 20622
	Baltimore, MD	Department of Health and Mental Hygiene. Important: If item 27 is marked other th injury or other traumatic event, the Med		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other Specify:		b. Place of Disp crematory or 3rinsiie			Date 4/20/2006	20c. Location - City Charlotte	or Town, State  Hall, MD
	Baltin permit.	Departm Importa injury o		21. Signature of Funeral Service License	St	22	Name and Ad Prinsfi .O. Bo	idress of Facility e1d-Ech x 128,	ols Funera Charlotte	l Home, P.A Hall, Mary	1 1and 20622
		sician edical		23a. Part I. Enter the disease, or complic failure. List only one cause on each	n line.	ath. Do not ente	er the mode of o				Approximate Interval Between Onset and Death
		miner			therosclerotic Card ue to (or as a consequenc		isease				
			Je.	it dily; leading to mini-	ue to (or as a consequenc	ce of):					_s
	eq	nsit	Examiner	events resulting in death) Last	ue to (or as a consequenc	pe of):					
	) e execut	physician and the burial - transit		UNPENDED d.	AMENDED						
	Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death centificate be executed	nding physi	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p  1 Live birth  Pregnant at time o	2	Fetal death Other (Specification)		c pregnancy	23d. Date of deliv Month	very Day Year
	Box he death o	gned by the attending detached for use	Physici	1 Yes 2 No 9 Unknown  Part II. Other significant conditions	9 Unknown				art I 23e. Did	tobacco use contribute	to the cause of death?
	P.O.	signed by be detac		Part II. Other significant conditions		or resulting in a				es 2 No 3 F	Probably 4 Unknown
	Division of Vital Records,	e has been s	Completed by						24a. Wa: auto perf 1 <b>V</b> Yes	opsy prior death	
,	al Re	s certificate } rector, page	Be Co	25. Was case referred to medical examiner?				Othor: F	(Check only one)		
	f Vit	After this c uneral dire	L C	1 Yes 2 No  27. Manner of Death	28a. Date of Injury	✓ ER/Outpati 28b. Time		A Other ₄	Nursing Home 5 28d. Describe	Residence 6 0	ther:
,	ion C	death. ctor: After t y the funeral	ation	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)			1 Yes 2			O - I O - to N - when City
	Divis	4 hours after of Funeral Directly filled in by	Certification:	3 Suicide 6 Could not b determined	(Specify)				or Town,	State)	Rural Route Number, City
	the Hos	within 24 he Fo the Fun completely	Medical (	one) 2 Medical Examiner:	n: To the best of my know	wledge, death or on and/or invest	ccurred at the ti	ime, date and popinion, death o	lace, and due to the cal ccurred at the time, dat	use(s) and manner as a e and place, and due t	started. o the cause(s)
_	, L	rwit Con	Mec	29b. Signature and title of certifier	and manner stated.			License number	ſ	April 16, 2006	
				30. Name and address of person who co	ompleted cause of death (	Item 23a)		O.C.M.E.		April 10, 2000	
				Ling Li, MD Assistant Me	edical Examiner	111 Penn St	reet, Baltim	ore, MD 21	201		
		c	tate	31. Date filed (Morth Day, Year) 7	16 32 Cegistrar's Sig	natu	and I				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Mary Erva Hancock 2006 April 18, 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF Months Director Yrs. 78 213-26-1343 Oct 20, 1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 5 "natural', or Itema 23a 25737 Three Notch Road 20636 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White ģ Specify: 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Je filed wit.

*I Hygiene.

*er than "pr Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: if Item 27 is marked other that eny Injury or other traumatic event, ITEM 2008. 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Earl Curry Alice Maude Vanwart 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Annette Hancock / Daughter-In-Law 25848 S. Sandgates Road Mechanicsville MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery Apr 22, 2006 Laurel Grove, MD 21. Signalare of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 nichael Delas Part 1. Enter the disease or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical schrotel Cordio Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Il-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 ☐ Other (specify) ed by the Records, P.O. 9 Unknown by the not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably e4b. Were autopsy find prior to completion death?

1 ☐ Yes 2 ☐ No autopsy performed page 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 1. Impatient 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death.

Director: Af
d in by the fur 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral C
completely filled i 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number 30. Name and address of person who completed cause addeath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

Tavaris Sharron Hewlett

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Ce	rtificate	of Death			g.0110	leg No.	Ub	1345
Physic Medical Exam		Decedent's Name (First, Midd					_	- 1	2. Date of Dea	ath	ear	3. Time of Death
Wedical Exam	iner	Tavaris  4a. Facility Name (if not institution	Sharron		wlett	I dh City Toy	n, or Location	of Death	April 18, 2	2006		1700 hrs
		Prince George's Hosp		imber)		Cheverl		of Death		4c. County Prince		's
Funeral	- E	5. Social Security Number	6. Sex	7. Age (In yrs	last birthday	) If Under 1	Year If Und	der 24Hrs.	8. Date of Bi	rth (MM/DD/YYY		
Director		219-96-3825	1 X M 2 F	2	4	Yrs. Months	Days Hour	rs Min.	06/26	/1981	Foreigr Cou	n IntryMaryland
-		Usual Residence of Decedent	-							7 1 3 0 1		Tidly Land
w an		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
Maryland 28a-f show any d at once.	to	Maryland St 10e. Street and Number	. Mary's				ornia					1 Yes 2 X No
th the Maryland 23a or 28a-f she notified at once	Director					10f. Zip Co			]1	0g. Citizen of W		
with th		45260 Insuran		cedent Ever in U	S 12	Was Decedent of	0619	rigin? / Con	oif: Van Na	Unite		
72 hours after death with the Maryland ""uatural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	1 X Never Married 2 M				If Yes, specify C	uban, Mexica	n, Puerto R	tican, etc.)		e - Americ te, etc.	an Indian, Black,
after c	by F		rorced If Yes, Give Yea	ar	1[	Yes 2 X	No specify	<b>y</b> .		Specify:	В.	Lack
136 hin 72 hours aftre e than "natural" dieal Examine		15. Decedent's Education (Spe	cify only highest grad			dent's Usual Oco				16b. Kind of B	usiness/Ir	ndustry
36 in 72 han " dical J	Completed	Elementary/Secondary (0-12)	College (1	1-4 or 5+)				r doo relire	۵,	_		_
5-0036 led within 72 Hygiene other than '	)om	11 17. Father's Name (First, Middle,	Last)			Lands	caper	er's Name (I	First Middle	Maiden Surname		caping
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be (	Michael Darn	ell Thoma:	s						Hewlet	,	
MD 21215-0036 2 should be filed within h and Mental Hygiene 27 is marked other tha marite event, the Medic	ို	19a. Informant's Name/Relations			19b. Mai	ling Address (	Street and Nu	mber or Ru	ral Route Nur	nber, City or Tov	vn, State,	Zıp Code)
, MD nd 2 sho alth and em 27 is		Ann Denise Hew 20a. Method of Disposition	lett / Mo							fornia,		
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the MA		1 X Burial 2 Cremation	3 Removal fro		crematory or	oosition (Name of other place)	or cemetery,		Date	20c. Location	,	.,
Itimeni rtmeni ortanti y or o		4 Donation 5 Other St.	pecify:	St		r Clave				Ridge		
Ba perm Depa Impo injur		Edward N. Brin		r. M000		2. Name and Add		DLI				ome, P.A.
Physician		23a. Part I Enter the disease, or	complications that ca	aused the death		r the mode of d	ying, such as o	d Koa cardiac or r	espiratory arr	nard town est, shock, or he	art MI	20650-027 Approximate Interval
/Medical xaminer		failure. List only one cause Immediate Cause (Final disease		ound of neck	k and hea	d						Between Onset and Death
Adminici		or condition resulting in death)	Due to (or as a	consequence o	f):							
	F	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	f):							
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated	С									
cecuted 1 and - transit	Exa	events resulting in death) Last	Due to (or as a	consequence o	f):		-					
execu an and al - tra	S	UNPENDED	AMENDED								$\overline{}$	-
8760, tificate be ex ng physician as the burial	n/Medical	IF FEMALE:		outcome of preg	nancv		_			23d. Date of	- f dolivory	
687 certific iding p	jan/	23b Was decedent pregnant in the past 12 months?	1 Live b	irth	2	Fetal death	3 Ectopi	ic pregnanc	у	Month	Da	y Year
Box 687.  he death certific  the attending properties of the seconds.	ysicia	1 Yes 2 No 9 Unk	known 9 Unkno	ant at time of de	ath 5	Other (Specify)						
O. E at the at the at the at the at the at the tached	Phy	Part II. Other significant conditi		death but not re	esulting in th	e underlying cau	use given in Pa	art I.	23e. Did to	bacco use contr	ibute to th	e cause of death?
s, P.O. irres that the signed by	d by								1 Yes	2 <b>V</b> No 3	Proba	bly 4 Unknown
Vital Records, hysician: The law require this certificate has been sidirector, page 2 should b	Completed								24a. Was a			psy findings available
Pecc	JE O						<del>,</del>	_	perfor	med?	death?	mpletion of cause of
tal Reciniment The certificate ector, page	o.	25. Was case referred to medical				26.F	Place of Death	(Check on			V Tes	2 No
Vitysic This of	TO B	examiner? 1 ✓ Yes 2 No	Hospital 1 / Ir	npatient 2	ER/Outpatie	ent 3 DOA	Other ₄	Nursing I	Home 5	Residence 6	Other:	
n of ding Pt After i funeral		27. Manner of Death  1 Natural 5 Pend	28a, Date of Month	of Injury Day,Year)	28b. Time of FOUND:		Injury at Work	- 10	Bd. Describe h ubject was	now injury occurr	ed	
Division al or Attendi rs after death al Director: //	cati	J Pend	stigation Apr 13, 2	2006	0150 hrs		Yes 2	] No				
Divis	Certification:		3 110, 20	of Injury - At ho Parking Lo		reet, factory, offi	ice building, et	i	or Town, St	tate)		Route Number, City
Hospi 24 hou Funer rely fil		20e C++f	nysician: To the best			curred at the time	e date and old			ut Road, St.		
Division of Vital Records, P.O. Box 68760, within 24 hours after death criticate be executed within 24 hours after death. To the law requires that the death certificate be executed for the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Medical	one) 2 Medical Exam	niner:On the basis o and manner st	of examination ai	nd/or investi	gation, in my opi	nion death oc	ccurred at the	ne time, date a	and place, and d	ue to the	cause(s)
	M	29b. Signature and title of certifie				29¢ Lic	cense number			29d. Date sign	ed (Monti	h, Day, Year)
		CMOX	_			0	.C M.E.			April 20, 20	)06	
		30. Name and address of person				Charles 5		0400				
	ate		istant Medical E	gistrar's Signatu		Street, Balt	imore, MD	21201				
Regist	ale tar	31 Date filed (Month, Day, Year) APR 2 1	2006	Complete A	1 de	180						
DHMH 17 Rev 1/2	001			N. W.	ORIGIN	AL						

			1 - For State Registrar	State of Maryla	nd / Depa <i>Ce</i> a	artment of H rtificate of	lealth and Death	Mental Hy	giene	13456
	Physic	ian	1. Decedent's Name (First, Middle, Last,				-	2. Date of De Month	eath	3. Time of Death
*	/Medi		Annamma	Israel				April	10 2006	1:35 PM
	Exami	ner	4a. Facility Name (If not institution, give Doctors' Community			4b. City, Town, o	r Location of Deal	h	4c. County of	Death Georges
4	Funeral	, C	5. Social Security Number 6. Sec		last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi		Birthplace (State or Foreign
	Director	Н	212-94-3777	M 2 AF 9	6 Yrs.	Months Days	Hours Min.	April	7, 1910	Country) India
	p ,		Usual Residence of Decedent  10a. State 10b. County	100.0						
	sho	ŏ	,		ity, Town or Lo					10d. Inside City Limits 1 Yes 2 □ No
	the N	ect	Maryland Prince  10e. Street and Number	Georges	Rivero	10f. Zip Code			10- 03	
	with sa or	0	6003 Norman Ave			207	37	1	10g. Citizen of Wha Inited Sta	ites of Americ
	death me 2:	Funeral Director		12. Was Decedent Ever in I	J.S. 13.1	Was Decedent of H			14 Race -	American Indian
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23s or 28s-1 show any injury or other traumatic avant, tra Medical Eval: the months of page.	by	1 ☐ Never Married 2 ☐ Married 3 ፟፟፟X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 □ Yes 2 🖔 No	sn, Mexican, Puer	to Rican, etc.)		white etc. As lan .nd lan
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation	diaa	16b. Kind of Busin	ess/Industry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	daning most of wo	ixiiiy		
2	lied w lygier lher ti		17. Father's Name (First, Middle, Last)		Но	memaker	40.44.4.4.4.	2000 A B 41 4 11	Own Ho	ome
and	ntal h	Be	Arumanahagum					^{ne (First, Middle} hapu	, Maiden Sumame)	
7	should Me mark mark	ပို	19a. Informant's Name/Relationship (Ty	pe. Print)	19b Mailir	n Address (Street		-	er, City or Town, Sta	to Zin Code)
	nd 2 :		Kantian J. Mark -						ring, MD	
Baltimore,	s 1 and 1 de la la la la la la la la la la la la la		20a. Method of Disposition	ľ	Place of Dispo	sition (Name of natory or other place	امر	Date	20c. Location - Cit	y or Town, State
Ĕ	Page nent control of try or	1	1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		hington		/14/06	Adelphi,	Maryland
att	permit. Departrimporta		21. Signature d Fun ral Service License	96			1000		ıldi Funer	56 HILL 100 1
<u> </u>	8 9 E 8 9		23a. Part1. Enterthe disease, or compli							ring, MD 2090
8760,	Physician /Medical Examiner building superprise physician and purial-!tausit superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physician and superprise physicia	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect  Due to (or as a consect	quence of):	(A)	~	_ ##	NYTHM	
O. Box 6	The law requires that the death certifica te has been signed by the attending ph tage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 conths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 0 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<u>α</u>	res that igned b be deta	by Pi	Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	derlying cause give	en in Part I.	23e. Did t	obacco use contribut	te to the cause of death?
rds	w require: been sig should b							10	Yes 2 No 3	Probably 4 Unknown
Records,	The law re ate has bee page 2 sho	Completed							rmeg? deat	
Vita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			_	26. Place of Dea			Yes 2 No
	Physician: r this certific ral director,	To	1 ☐ Yes 2 ☐ No	ospital: 1 Unpatient 2	ER/Outpatient	3□ DOA Othe	er: 4 🗆 Nursing H	ome 5 🗆 Resid	dence 6 Other (S	Specify)
U C	tending Physician: leath. tor: After this certific the funeral director,		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe I	now injury occurred	
<u>s</u>	Attending or death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				res 2 □ No			
Division of	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Certification:	4  Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy) 			City or Tov	vn, State)	r Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of	ledical	one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	e, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier			29c. License	number	,	29d. Date signed (M	fonth, Day, Year)
	_					DO	818		04-10	1-1000
	5		30. Name and address of person who con	npleted cause of death (Iter	n 23a) (Type, f	DV /	7 1	14 m	D DAM	7.0
	Sta Registr		31. Date filed (Month Day Year) 4 20	32. Pigistrar's Signa	ature	and C	TEEN DE	(16, 11)	0011	due to the cause(s)  Youth, Day, Year)  10-2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#18 PERFH C856 6/5/06 WS
State of Maryland / Department of Health and Mental Hygiene
1- State Amend# 1, 4-21-06, per Dr., WHI Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:29 AM RINE Bodner April 2006 Ш /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita HODKINS Johns H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 12, 1 None 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Months 1□M 2₩F Yrs. Director 185 22 8388 1928 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9772 Old Annapolis Road 21042 United States Items 23g Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 'neturel', White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname)
Anna Mary Sates 17. Father's Name (First, Middle, Last) Be 2 should be Stephen Bodner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is John Iannuzzi/Husband 9772 Old Annapolis Rd Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ pernit. Page Department of Important: If any njury or once. 4-18-2006 `4 ☐Donation 5 ☐ Other (Specify) New Cathedral Cem. Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc.  $\Omega$  M01044 oll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician days disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 No 24a. Was an 2**X** No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3 DOA s after death.

I Director: After this of in by the funeral d Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tyes 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOODWORTH OLFE gistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 14 2006

aprened t

State of Maryland / Department of Health and Mental Hygiene | | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 10 Melvin John Jackson Рм 2006 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 21, Birthplace (State or Foreign Country) **Funeral** XXM 2 F 67 Director 215-34-8882 Yrs 1938 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow r Items 23s or 28s-f show Maryland Anne Arundel Crofton 1 TYes 2XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1910 Topango Place 21114 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e eny Injury or other traumatic event, the Medical Exemplent: wall once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ②No Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineering Tech U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Jackson Elsie Fischer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janice Jackson/wife 1910 Topango Place Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 

Cremation 3 

Removal from State Hillcrest Mem. Gardens 4/13/2006 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (anes **Physician** nh-Years /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the attending physicien and ched for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 240 1 Yes 2 40 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending 1 Nutural investigation 1 ☐ Yes 2 ☐ No М 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of	Marylar		artment of F		nd Menta		ene ()	0.5	134	59
	Physicia	an	Decedent's Name (First, Middle	, Last)						te of Death	Day	Year	3. Time of	Death
	/Medic			IDA	Α.	J	OHNSON					2006	2:00	P ^M
,	Examin	er	4a. Facility Name (If not institution		ber)		4b. City, Town, o	r Location of E	Death			ty of Death		
			HOWARD S HOU  5. Social Security Number		7 Ama (In	Jana hintaria. A	MIDDLE If Under 1 Year	BURG	Hrc. I a =		CAF	ROLL		
	Funeral Director		216-30-3829	1 M 2X F	90	last birthday) Yrs.	Months Days		Min. (Mc	te of Birth onth, Day, y 8,	1915	9. Birthi Cour Mary		· Foreign
and	* = 1		Usual Residence of Decedent  10a. State 10b. County	•	10c. Ci	ity, Town or Lo	cation					1	IOd. Inside Cit	v Limits
Mac	a t	ō	Maryland Freder	cick	м	lonrovia	a						1 🗆 Yes	•
death with the Marviand	28s	Directo	10e. Street and Number	ICK		OHIOVI	10f. Zip Code			10	g. Citizen of	What Cour		
wit.	38.0		3997 Rye Lat	125 °.			2177	0				U.S.	•	
		Funeral	11. Marital Status	12. Was Deced	tent Ever in U		Was Decedent of H	lispanic Origin	? (Specify Ye	es or No-	14. Ra	ice - Americ	an Indian,	
عربو و	or ite		1 ☐ Never Married 2 ☐ Marri		2 <b>[</b> 4 <b>N</b> 0		1 Tes, specify Cuba 1 ☐ Yes 21X No	Specify:	rueno nican,	etc.)		ack, White,	etc.	
within 72 hours after	Exa	d by	3 XWidowed 4 ☐ Divorced	Year or Da	tes:		165 222110	Specity.			Speci	"y: Whi	te	
2 2	nat	Completed	15. Decedent' (Specify only highes			(Give	dent's Usual Occup kind of work done	during most of	f working		Sb. Kind of I			
Z iţi	than than	щ	Elementary/Secondary (0-12)	College (1-	4or 5+)		DO NOT use retired Service	•	•	1	_		County	
N B	vental Hygiene. irked other then itic event, the M	e C	17. Father's Name (First, Middle, L	.ast)		Food	Service		Name (First,		Public		OIS	
	Mental arked c atic ave	To B	Levin Beauch	amn				Sara	_	kes		<b>-</b> /		
Shou	nd M mar	-	19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street				City or Town	n, State, Zip	(Code)	
<b>2</b>	Depertment of Health and Menta important: if Item 27 is marked any injury or other traumatic as ones.		Bonnie Lou Glot	felty - G	anddai	ichter	3997 Rv	a Lane.	Monr	envia.	More	hand.	21770	
5 . S	item oth oth	ll š	20a. Method of Disposition		206.	Place of Dispo	sition (Name of natory or other place		Date	20	c. Location	- City or To	own, State	
altimo	int: if		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		tate	-	g Cemete	1	/15/06	C	larksi	oure.	Maryla	nd
	Depertn Imports eny inju		21. Signalure of F) neral Service L	icensee ( . A 4			Name and Address		oma D	A T		1 11	nary ra	iiid
0 8	8 3 5 6		Forest L.	Nelle	ams	2	6401 Ride	re Road	. Dam	A., F	unera	T Hom	e <u>20</u> 87	72
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that ca	used the deat	th. Do not ente	er the mode of dyin	ig, such as car	rdiac or respir	ratory arres	t,	y zana	Approximate Interval Betw	
P	nysician		Immediate Cause (Final disease or condition	Ather	20 solf	ceotic	CARDIOU	COCOLA	n Duec	we			Onset and D	
	Medical xaminer		resulting in death)	_ a	r as a consec								11014	
_	xammer		Sequentially list conditions,	b										
þ	sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	ras a consec	quence of):								
xecut	and II-tran	Examiner	that initiated events resulting in death) Last	c	r as a consec	uence of):							_	
ate be e	sicien					(444.144								
DO /	phys s the	edical	, y	d										
CAL	nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d D	ate of delive	NO.	-
death	d for	cla	in the past 12 months?	4□Pregna	th 2.∏Feta ntattime of d		Ectopic pregnancy Other (specify)					onth	-	ear
) \frac{1}{2}	by the	hys	9 Unknown	9□ Unknov	VTI									
Sthe	been signed by the attending physicien and should be detached for use as the bunat-transit	by P	Part II. Dther significant condition	ns contributing to dea	th but not res	ulting in the un	nderlying cause give	en in Part I.	23	e. Did toba	cco use cor	tribute to th	e cause of de	ath?
w requires 1	en sig								_	1 🗌 Yes	2 No	3 Prob	ably 4 □Ur	ıknown
a v	as be 2 sh	Completed							24:	a. Was an autopsy	24b.	Were auto	psy findings av	vailable
_ #	page	ē							1	performe	A? SNo	death?	npletion of car	126 01
	ertific ictor,	Be (	25. Was case referred to medical examiner?					26. Place of	Death (Check					
Physic C	his ca	ူ	1 ☐ Yes 2 No			ER/Outpatien		4 LI Nursin	ng Home 5(	Residen	e 6 <b>X</b> JOt	her (Specify	ASSIS	STED
a gri	After t	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending		Injury Day Year)	28b. Time of Injury	28c. Injury Work		28d. De	scribe how	injury occu	rred	LIVIN	1G
r Attending	tor: /	cat		ot be				Yes 2 □ No						
Or A	Dirac Dirac in by	Certification;	4 ☐ Homicide determin	ned 286. Place of building	t Injury - At high etc. (Specif	ome, tarm, stre fy)	eet, factory, office		28f. Loc City	ation (Stre	et and Num State)	ber or Rura	i Route Numb	er,
spite	within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying	Physician: To the b	est of my kno	wledge, death	occurred at the time	ne, date and o	lace, and due	to the carr	sa/s) and -	anner ce ct	ated	
e Ho	P Full	edical	(Check only 2 Medical E	xaminer: On the bas and manne	is of examina	ation and/or inv	estigation, in my or	pinion, death o	occurred at the	e time, date	and place,	and due to	the cause(s)	
Ġ	들도요	Me	29b. Signature and title of certifier				29c. License	number		290	Date signe	ed (Month, I	Dav. Year)	
5	To	-	ESS. Organization data title of destance.											
Tot	To		1 Prima	K. Ga	en-	14	2	31660		0	4/10/:			
5	Ton		1 Prima 30. Name and address of person w	no completed cause	of death (Item	n 23a) (Type, I		31660		0	4/10/			
ToT	S 2 min		1 frma	IN wile	of death (Item 29) gistrar's Signa	STOW				<u> </u>		2006	rudand r	11957

			1- For Amend Item 2. Registrar 23aPi	State of Man per ME, G8	dand / Dei 57,0772	partment of 0/0/dhb ertificate o	Health and	d Mental Hy	giene 006	13460
	Physici		Decedent's Name (First, Middle, Last     Mavis		i oh t	-		2. Date of De. Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give		ight	4b. City. Town	n, or Location of De	April	. 11, 2006 4c. County of Death	<u> 4:15P ™</u>
	Exami	e	Genesis Elden			is. oxy	La Plat			rles
	Funeral		5. Social Security Number 6. Se	x 7. Age (Ir	yrs. last birthda	y) If Under 1 Ye	ar If Under 24 h	rs. 8. Date of Birt		place (State or Foreign intry)
	Director		Usuel Residence of Decedent	M 2 F 7	79 Yrs.	Months Day	ys Hours M	Detober	31,1926 Cou	Virginia
	arylan ahow	_	10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	the M 28a-f	Funeral Director	MD Char 1	es	La Pl				10.00	1 XYes 2 No
	With With	iDir	One Magnolia I	rive		10f. Zip Cod	20646		10g. Citizen of What Cou USA	intry?
	death ms 2;	era	11. Marital Status	12. Was Decedent Ever	r in U.S. 13			(Specify Yes or No		ican Indian.
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, I'm Medical Examiner must be notified at once.	by Fur	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		If Yes, specify C 1 ☐ Yes 2 💢 N		(Specify Yes or No lerto Rican, etc.)		
20	72 hou	ted	15. Decedent's Edu (Specify only highest grad		16a. Dec	edent's Usual Oct	cupation ne during most of v	warking	16b. Kind of Business/li	ndustry
2	vithin han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use ret	ired)	WOIKING		
2	Hygie Hygie ther t nt, th	S	17. Father's Name (First, Middle, Last)		01	fice Cl	1	iame (First, Middle,	Union Ele	ectrical
Maryland 21215-0036	should be ind Mental I marked o	To Be	Thomas Jackson				Eliza	abeth 0'	Connor	
, Mar	and 2 shealth and a 27 is m		19a. Informant's Name/Relationship (T) Thomas Click/So	, , ,				Rural Route Numbe	ar, City or Town, State, Zi ata, MD 2	0646
Baltimore,	Pages 1. nent of He int: If iten iry or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Ramarial from Chata	cemetery, cr	oosition (Name of ematory or other p	cans 4/1	Date 18/06 C	20c. Location - City or T heltenham	
Balti	permit. I Depertm Importar any Injur		21. Signature of Funeral Service Licens	ee / MOC	The second second	22. AREHAT	tt-Echoi	LS FUNER	AL HOME, P	.A.
			23a. Part1. Enter the disease, or compl	ications that caused the	death. Do not e				TA, MD 20	Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Multipue to (or as a co		myel		,	-	Interval Between Onset and Death
	/Medical Examiner			Due to (or as a co	nsequence of):	•			. 1	To Take
	p. 11	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	niaequance of).				14/	
oʻ	cate be executed obysician and the buriel-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):			N 17	ONED BY MEDICAL	of R
68760,	ficate be physici s the bu	edicai		d	·····			7	PROVED BY MEDICAL	
Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use es the buriel-transit	Physician/Medical	in the past 12 months?	t3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnar		CERTIFICATION	23d. Date of deliv	ery Day Year
P.O.	that the de led by the a detached t	Phys	1 Yes 2 No 9 Unknown  Part II. Other significant conditions con	9☐ Unknown	at reculting in the	underhing onus	nuon in Part I	22a Did to	bacco use contribute to	ho access of de-sth2
ords,	w requires that been signed be should be det	ted by	ANEMIA			andenying cacse	givon arr arr.		es 2 □ No 3 □ Pro	
Division of Vital Records,		Completed by	PARAPLESIA					24a. Was a autop perfor	sy prior to co	opsy findings available impletion of cause of
ita	ysicien: The lis certificete ha director, page	Bec	25. Was case referred to medical				26. Place of D	eath Check only or		2310
<u>&gt;</u>	Physic this ce al dire	2	examiner? 1 X Yes 2 X No	fospital: 1   Inpatient	2 ER/Outpatie	ent 3 DOA	Other: 4 Nursing	Home 5 Resid	ence 6 Other (Speci	(y)
onoi	ding P	ation:	27. Manner of Death  2 Natural 5 □ Pending 2 □ Accident investigation	jury at /ork? Yes 2 No		ow injury occurred				
DIVIS	of or Attended to the or Attended in Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s	treet, factory, office	e	28f. Location (S City or Tow	treet and Number or Run n, State)	al Route Number,
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edicai C	29a. Certifier 1 orti ying Physical Check only 2 Medical Exami	sicien: To the hest of moner: On the basis of exa and manner stated.	y knowladge, dae mination and/or i	ith scourfed at the nvestigation, in my	time, date and pla y opinion, death oc	ide, and dud to the e curred at the time, o	ausa(s) and manner as s date and place, and due t	stated. o the cause(s)
	To the vithir comp	Me	29b. Signature and title of certifier	1 4			nse number		29d. Date signed (Month,	
			1 16 ah	1 AH	ENDI	19 D	44436		APRIL 12	2006
	16,0	1	30. Name and andress of person who co	mpleted cause of death	(Item 23a) (Type	Print)	4	1.1.11.	APRIL 12	0.4
	Sta	te	31. Date filed (Month, Day, Year)	32. Jegistrar's S	Signature	1100 CF	1102	WARRO	er, 1111	20602
	Registr	ar	APR 1 4 2	106 Alexander	15. 16	bod!				

			For	State of Mary	•	artmen	t of H	ealth a			giene	106	13161
			State Registrar		Ce	rtificat	e of L	Death			Reg. No.	اليا ليا اليا	10701
	Physici	20	Decedent's Name (First, Middle, Las							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Francis Eugene K							April	10	2006	3:15 A M
	Examin	er	4a. Facility Name (If not institution, give					Location of	Death			ounty of Deatl	
			6423 Palmers Mill 5. Social Security Number 6. Se		yrs. last birthday)	Hurl If Unde		If Under 2	4 Hrs.	8 Date of Birt		chester	hplace (State or Foreign
	uneral			X M 2□F	57 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da Jan 19	Year)	9 Mary	untry) y Land
	irector		Usual Residence of Decedent					1		J 2.	,,_,	7 1	
) larytand	MON W		10a. State 10b. County	100	c. City, Town or L	ocation							10d. Inside City Limits
)≥	1	tor	Maryland Dorchest	er	Hurlo	ck							1 ☐ Yes 2 🖾 No
2 ਵ	28 no	Director	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Co	untry?
death with the	n'natural, or iteme 23a or 28a-f show ledical Examiner must be notified at	al	6423 Palmers Mi	11 Road				543				USA	
2 §	E E	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Dece II Yes, spe	dent ol Hi cify Cuba	ispanic Orig in, Mexican,	in? (Spe Puerto l	ecify Yes or No Rican, etc.)	- 14	. Race - Ame Black, White	
OU35 (	o.	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No		1 ☐ Yes	2 🛚 No	Specify:			s	pecify: Wh	ite
3 5	tural a Ex		15. Decedent's Ed	Year or Dates:	16a Dece	ident's Usu	al Occupi	ation			16b. Kind	of Business/	Industry
within 72	podici	olet	(Specify only highest gra-	de completed)	(Give	kind of wo	ork done d se retired	during most	of workii	ng	Truck	ing an	.d
N with		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Pres	ident	and	CEO			Ware	housin	g
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Marian Huriana	d other then	BeC	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·			18. Mother	's Name	(First, Middle,	, Maiden S	umame)	
ald be		To B	Francis N. Koski					Bonn	nie I	Lee Tod	d		
aryla should b	Item 27 ie marke other traumatic		19a. Informant's Name/Relationship (7	ype, Print)		•	•			l Route Numbe			
C 7	n 27 i		Suzanne Koski/Wif					Mill					nd 21643
Baltimore,	in the		20a. Method of Disposition  1 XBurial 2 Cremation 3	Removal from State	Ob. Place of Disp cemetery, cre	matory or	other plac			ate	20c. Loca	ition - City or	Town, State
Pag Pag	ant: I		4 □Donation 5 □ Other (Specify		423 Palm					2006	Hur1	ock, Ma	aryland
Salt ermit.	important: If ite eny injury or ot once.		21. Signlature of Funeral Service Licen	see )	$\frac{1}{2}$	2.Namea eller	nd Addres	ss of Facility eral H	, Iome	. P. O.	Box	207	
ш ас	) = = a	1	Jeneux 4	o ecc						P. O.		t, MD	
		-	23a. Part1. Enter the disease, or composition of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th	one cause on each line.			_				rrest,		Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition	a_ Par	ncrea	tre		an	cer				10 months
	ledical aminer		resulting in death)	Due to (or as a co	nsequence of):								
		-	Sequentially list conditions,	b. Due to for as a co	ns Juence of	<del></del>							
bet	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
эхөсг	n end al-tra	Exal	that initiated events resulting in death) Last	c.  Due to (or as a co	nsequence of):								
<b>760,</b> e be executed	physicien end s the burial-transit	call		d.									
	ettending phy I for use as the												
O P Ceerl	nse	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		□Ectopic p	regnancy	,			23	d. Date of del	
Geal	ed for	100 N	in the past 12 months? 1 🗆 Yes 2 🗆 No	4☐Pregnant at time		Other (s						Month	Day Year
P.O.	by the stached	by Physician/Med	9 Unknown							an- Did			the serves of death?
	igned be det		Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying	cause giv	en in Part I.		1	Yes 2 🖸		o the cause of death?
Records, The law requires t	should be	Completed								''	195 205	140 3 11	——————————————————————————————————————
a w	2 3	nple								24a. Was	psy	24b. Were at prior to death?	utopsy findings available completion of cause of
E .	pag	S								1 ☐ Yes	2 No		2 ₽ No
Division of Vital	ector	Be	25. Was case referred to medical examiner?	Hospital:			OA Oth	or		Check only			
of shapes	this o	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient	2 ER/Outpatie		OA Our	4 🗆 I (u)	-	me 5 ☑ Resi 28d. Describe			icity)
L G	After funer	lo Lo	1 Matural 5 ☐ Pending	(Month, Day Ye	nar) Injury	м	Wor	k? Yes 2 □ N					
Vision of Vital	ctor: / the	Ical	3 ☐ Suicide 6 ☐ Could not b	e Blace of Injunt	At home, farm, s							Number or Ri	ural Route Number,
S S	Dir	Certifications	4 Homicide	building, etc. (S			,			City or To	wn, State)		
Hospital or	nerei nerei fillec			ysician: To the best of m									
e Ho	winin 24 routs arist deaut.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exar	niner: On the basis of example and manner stated		nvestigatio	n, in my c	pinion, deat	th occurr	red at the time,	date and p	place, and due	e to the cause(s)
Toth	To the	X	29b. Signature and title of certifier	) ^ -		25		e number				signed (Mont	
			Inek	grady D	70		He	4735	57		4-	10 -:	2006
			30. Name and address of person who	completed cause of death	(Item 23a) (Type		7	Anne L	. G1	cady, D	.0.		
			8221 lea	1 60.8	ute s	204	-	asto	n,	MU	2	1601	
	St Regist	ate	31. Date liled (Month, Day Year)	2006 ^{32. Registrar's}	aignature /	Loon	K						

			For State Registrar	State of Ma	aryland / Dep Ce	partment of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learning of learni			giene 0 6	13462
	Physici /Medio		1. Decedent's Name (First, Middle, La	mda				2. Date of Dea Month	Day Year	6 2 PM
	Examir Funeral Director	ier	212-68-1829	Nursing	Home (In yrs. last birthda 48 Yrs.	Carton		s. 8. Date of Birt		ath  Or (  inthplace (State or Foreign Spinity)  shington, DC
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltin	iore	10c. City, Town or Catons					10d. Inside City Limits 1 Yes 2 □ No
	h with the 23a or 28 st be no	al Director	10e. Street and Number 701 Edmonson Ave	e Rm 2043		10f. Zip Code 212	.28		10g. Citizen of What C nited Stat	country? es of Americ
036	72 hours after death with the Maryland natural', or itams 23a or 28a-1 show disal Examinat must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ※Divorced	12. Was Decedent E Armed Forces? 1€ Yes 2 □ N If Yes, Give Year or Dates:	79–85	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
21215-0036	within ane. than "	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5-	(Gir	redent's Usual Occur re kind of work done DO NOT use retire T. Opera	during most of word)	orking	16b. Kind of Busines  Compute	·
land 2	ild be filed lental Hygid ked other ic event,	To Be Co	17. Father's Name (First, Middle, Las Charles Henry			- F	18. Mother's Na	ame (First, Middle, Lou Ber	Maiden Sumame)	
Maryland	ind 2 should be alth and Mental alth and Mental 27 is marked or traumatic ever		19a. Informant's Name/Relationship Connie Lou Kruhr	<i>Туре, Print)</i> 1 Somervill	e - Siste	iling Address <i>(Stree</i> r 6621 F	t and Number or F laviland	Rural Route Numbe	r, City or Town, State, d, Clarksv	Zip Code) ille 21029
altimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tre once.		20a. Method of Disposition 1	(b)	Union C	ematory or other pla emetery	04/	Date 18/06	20c. Location - City o	lle, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	nsee						al Home, Inc. ing, MD 2090
8760,	Physician and Marketine physician and physician and the prutal-transit	I Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or as a c.	a consequence of): a consequence of):	IS				Interval Between Onset and Death
O. Box 687	aath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnanc	зу		23d. Date of de Month	elivery Day Year
σ.	es that igned b	by	Part II. Other significant conditions	contributing to death bu	at not resulting in the	underlying cause g	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Vital Records,	The law ate has t page 2 s	Completed	"BUSPHACTIA	*				24a. Was a autop perfor 1 Yes	sy prior to	autopsy findings available completion of cause of
o	Attanding Physician: Th r death. sctor: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1  Inpatie	y 28b. Time	of 28c. Inju	her: Nursing		ne) ence 6 ⊡Other (Sp ow injury occurred	ecify)
Division	tal or Attanus after deatl	Certification:	3 Suicide 6 Could not determined	28e. Place of Inju- building, etc	ry - At home, farm, : . (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or At within 24 hours after o To the Funaral Dirac completely filled in by	edical	29a. Certifying P (Check only one)  Certifying P 2 Medicel Exe	hysicien: To the best of miner: On the basis of and manner sta	examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time, o	ause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the I within 2 To the I complet	Z	29b. Signature and title of certifier	Lalha	er.		se number		29d. Pate signed (Mor	nth, Day, Year)
	12		30. Name and address of person who TASNEEM	AKHANI	7220	PARK	HEIGH	73 Ari	BALI	o Modiza
	Sta Registr	-26	APR 1 4	32. Registrá	r's Signature	bark				

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland /				lealth and Death		Re	g. No.	006	13463
r,	Physici	an	1. Decedent's Name (First, Middle, Last)								ate of Deat Month 111	10ay	2006	3. Time of Death
	/Medic	al	Linda S. Kat  4a. Facility Name (If not institution, give				4h City	Town	Location of De				County of Death	
	Examin	er	Holy Cross H				,		Spring				ontgome	
4000	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last t	oirthday)		r 1 Year	If Under 24 H	rs. 8. D	ate of Birth	Year)	9. Birth	place (State or Foreign
	Director		579-54-0583	]M 2 <b>X</b> ĴF	65	Yrs.	MONUIS	Days	Tiodis	Au	g. Is	, 79	40 Wash	fington, D.C
	pu k		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation							10d, Inside City Limits
	Aaryla Febo	ō		W17	Wheat	on								1 TYYes 2 □ No
	28a-	rect	Maryland Montgome  10e. Street and Number	Ly	Wilcac		10f. Z	ip Code			11	0g. Citiz	en of What Cou	intry?
	3a or	ig D	2308 Hermitage Ave	nue				20902	2			U	J. S. A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	Ever in U.S.	,		edent of Hearty Cubi	lispanic Origin? an, Mexican, Pu Specify:	(Specify 'erto Ricar	Yes or No- n, etc.)		4. Race - Amer Black, White Specify: Whi	, etc.
3	2 hou	ed	15. Decedent's Edu	cation	16	a. Dece	dent's Us	ual Occup	ation			16b. Kir	nd of Business/I	ndustry
212	hin 7.	pie	(Specify only highest grad	College (1-4or 5	+)	life.	DO NOT	use retire	during most of v d)	VOIKIIIG		-	2	
2	ed wit	Completed		4 Year	S	S	ecre	tary	40 14-4-4-1	I /F*:-			Private	
nd	be file d oth	Be	17. Father's Name (First, Middle, Last)						18. Mother's N		st, Middie, M Irtenh		Sumame)	
<u> </u>	ould J Men narke	ဥ	David Shapiro  19a. Informant's Name/Relationship (T)	no Print)	1	Oh Mailir	an Addre	es (Stroot					Town, State, Z	in Code)
ā	d 2 st th and 7 ts n traun		Howard Katz - Hus		1	2308	Her	mita	ge Aveni	ie, W	heato	n, N	Maryland	20902
altimore, Maryland 21215-0036	Heall Heall tam 2		20a. Method of Disposition		20b. Place	of Dispo	sition (N	ame of other pla	cal	Date		20c. Lo	cation - City or 1	Town, State
<u> </u>	Pages ent of nt: If i		1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Unit					11-20	006	Hal1	thorpe,	Maryland
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	Stattle	myer	1	091	Rock	ss of Facility gel Fun ville P	ike.	Rockv	i111	n, Inc. e, Mary	land 20852
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each lin	ne. De am i	o not ent	er the mo	de or cyr	oge Syn	drome	pilatory arr	951,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			ту п	ISLI	ess Syn					
	Examiner			Due to (or as	aconsequenc mial P:		onia							
	TES.	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a			UIIIa							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Conge	stive	Hear	t Fa	ilure	2					
oʻ	cate be executed physician end the burial-transit	Ex	resulting in death) Last	Due to (or as		ce of):								
68760,	ate be hysici	dicai	•	d. Sepsi	S					-				
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician end 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic Other (	pregnand specify) _	у			2	23d. Date of deli Month	very Day Year
	uires that t signed by id be detai	by	Part II. Other significant conditions co	ntributing to death b	ut not resultin	g in the u	ınderlying	cause gr	ven in Part I.			bacco u es 2[		the cause of death?
Records,	e - e	Completed								-	24a. Was a autops perform	Sy	24b. Were au prior to death?	topsy findings available completion of cause of
Vital	ician: Th certificate ector, pag	0	25. Was case referred to medical	P-19.00					26. Place of I			^	103	2.7.0
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 █️No	Hospital: 1 🔀 Inpatie	ent 2 ☐ ER/	Outpatie	nt 3□ I	OCA O	ner: 4 🗆 Nursin	g Home	5 🗌 Resid	ence (	6 □Other (Spec	cify)
Division of	5 e		27. Manner of Death  1X Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		b. Time o	of M	28c. Inju Wo 1	ryat rk? ]Yes 2 ∐No	28d.	Describe h	ow injur	y occurred	
Divis	tal or Atters as after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et		, farm, st	reet, fact	ory, office			Location (S City or Tow			ıral Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai		rsician: To the best iner: On the basis of and manner sta	f examination		rvestigati	on, in my	opinion, death o		t the time, o	late and	place, and due	to the cause(s)
	To t withi To tl	Σ	29b. Signature and tale of certifier				1		se number				te signed (Mont	
	10		Parglin					Do	o55148			Apr	il 10,	ZUU0 
51.0	/0		30. Name and address of derson who of Dr. Delroy Ans	ompleted cause of d	) Fores	st Gl	.en F		Silver	Spr	ing, M	lary	land 2	0910
100	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 1 3	32. Registr	rar's Signature	. 4	part	0						

06-02434 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Kinman, Dennis 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 9, 2006 12:04 Medical Examiner Kinman 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Frederick 5771 Mussetter Court **New Market** If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director April 5,1966 Maryland 1 X M 2 218-98-9261 Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Frederick New Market 72 hours after death with the Maryland Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5771 Mussetter Court 21774 United States Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc 1 Never Married 1 Yes "natural", or 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) ages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene t: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 Tattoo Artist Tattooing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Mary Woodbury Kinman Tayman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic 5771 Mussetter Ct., New Market, MD 21774 Lenora Kinman / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State permit Pages 1:
Department of H
Important: If ii crematory or other place) 1 Burial 2 *Cremation 3 Removal from State 04/13/2006 Frederick, Maryland Frederick Crematory 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1621 Oposummtown Pike, Frederick, MD 21702 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician iter the disease, o failure. List only one cause on each line. Cocaine intoxication complicated by hypertensive een Onset and /Medical Death a atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit The law requires that the death certificate be executed Physician/Medical AMENDED item#23a,27,28a-f,perME,g855,5/1/06 TT [X] UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth Fetal death 3 Ectopic pregnancy Month Day 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been s il director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?
1 ✓ Yes 2 No death? 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: After this certificompletely filled in by the funeral director; 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other: Nursing Home 5 Residence 6 Other: Scene DOA 1 🗸 Yes 2 No 28b. Time of Injury 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 y No 5 Pending Fnd 4/9/2006 Fnd 11:45 AM ımk 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide New Market, 1071 Mussetter Court determined (Specify) Found at residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and tille 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E April 10, 2006

State Registrar

31 Date filed (Month, Day, Year) 32. Regis APR 13 2006

completed cause of death (Item 23a)

30. Name and address of berso

Mary G. Ripple MD.



Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 10/2003

1	3	1	1	1
1	4	1.3	13	0.70
24.00	3	213	U	10

			1 - For State Registrar	State of M	arylan		artment of rtificate of				giene Reg. No	000	13465	
Phy:	cicia	n	1. Decedent's Name (First, Middle, La	st)				,		2. Date of Dea Month	ith Da	y Year	3. Time of Death	
	edica		GLADYS		ZABET	TH I	KAS			APRIL		2006	11:50 P ^M	
Exa	mine	er	4a. Facility Name (If not institution, give				4b. City, Town,				4c.	. County of Deal		
	1		Northampton Mano 5. Social Security Number 6.5			last birthday)		deric		8 Date of Birth		Frederi		
Fune Direct				I	84	Yrs.	Months Days		Min.	8. Date of Birth (Month, Day June 25	Year)	21 New	thplace <i>(State or Foreigr</i> buntry) York	
pu »			Usual Residence of Decedent		10.00				-					
laryla shov		č	10a. State 10b. County Maryland Frede	rick	10c. City	y, Town or Lo	ocation ersville						10d. Inside City Limits	
the M		ect	10e. Street and Number			Walk	10f. Zip Code				10- 01		1 ☐ Yes 2 No	
with Sa or			8779 Hickory Hill Rd .			10f. Zip Code 21793						izen of What Co ited St	tates	
death		nera	11. Marital Status	12. Was Decedent			Was Decedent of	Hispanic C	Origin? (Spe	cify Yes or No-		14. Race - Ame	rican Indian,	
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland of other then "natural", or items 23e or 28e-f show event, the Modical Examinar must be notified at		by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:			fYes, specify Cut 1☐ Yes 2 <b>1</b> (ÎNo			Rican, etc.)		Black, White	_{e, etc.} √hite	
72 h natu		etec	15. Decedent's Englishest graduate (Specify only highest graduate)			16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during me	ost of workin	ng	16b. Ki	ind of Business/	Industry	
within sne.		Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)			ed)						
D D = 1		္မွိ	17. Father's Name (First, Middle, Last,	}		Hom	emaker	18 Mot	her's Name	(First, Middle,		wn home		
		To Be	Charles		Lur	ton			zabetl		_	rubing		
d 2 should be file th and Mental Hy 7 is marked oth treumatic event	ļ		19a. Informant's Name/Relationship (	Type, Print)			ng Address (Stree						Zip Code)	
CENL			Susan E. Millione	/ Daughte			Hickory		Rd .	/ Walke	ersv	ille, M	D 21793	
- I 5 5			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pi	lace of Dispo emetery, crei	sition (Name of natory or other pla	ice)	Dá	ate	20c. Lo	ocation - City or	Town, State	
rmit. Peges 1 ar partment of Hea portant: If Item			4 ☐ Donation 5 ☐ Other (Specif	y)	Ca1		Nationa						New York	
permit. Peges Department of Important: If It	Duce		21. Signature of Funeral Service Licer	1599	4)		Name and Addr						I	
		-	23a. Part1. Enter the disease, or com	plications that caused	the death		521 Opos					LCK, MD	21702	
Dhusisis			shock of heart failure. List only Immediate Cause (Final	one cause on each lin	ne.					- `	est,		Approximate Interval Between Onset and Death	
Physicia /Medic	_		disease or condition resulting in death)	a. SUSTON Due to (or as	a consequ	CUT to	ulure 1	Con	gesti	ve)			year S	
Examin	er		AND DESCRIPTION OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF	200 10 (0) 00	a oonsoqu	JOHOO 017.			•				0	
p #		Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as	a consequ	ence of):								
ecute and trans		that initiated events				o (or as a consequence of):								
ficate be executed physicien and sthe burial-transit	L.	<u> </u>	and an additive East	Due to (or as	a consequ	ence of):								
icate phys s the	5	adical		. d.		_					-			
nding use as		I MI	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d Date of deli	VAD.	
death e atte d for		20	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal d  4 ☐ Pregnant at time of dea				death 3 ☐ Ectopic pregnancy				-	23d. Date of delivery  Month Day Year		
at the by the techer		Physician/m	9 Unknown	9□ Unknown										
es the gned Se de	3	Dy L	Part II. Other significent conditions c		ut not resu	lting in the ur	nderlying cause gr	ven in Part	I.	23e. Did tob	acco u	se contribute to	the cause of death?	
The law requirence has been sage 2 should		3	Diabetes Mellitis 10 Yes 2 No 30 Pr						obably 4 Unknown					
			Lymphoma	·				24a. Was ar	autopsy prior to comp		topsy findings available ompletion of cause of			
		3								perform	ńed? ⊠ No	death?	2□ No	
iclan: certificel ector, p	0	Δ .	25. Was case referred to medical examiner?	Hospital:			. 04			Check only on				
Phys rthis ral di	F		1 Yes 2 No 27. Manner of Death	1   Inpatie		R/Outpatien 28b. Time of	28c. Inju	191: 4)K(N	lursing Hom	e 5 Reside	nce 6	Other (Spec	ify)	
ding th. : Afte	1		1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year)	Injury	Wo	rk? Yes 2□		od. Describe no	iw injury	y occurred		
Atter r dea ector by the	9	20	3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office. 28th						28f. Location (Street and Number or Rural Route Number.					
s afte	1	Cermication	4 Homicide determined building, etc. (Specify)						, State)	tate)				
he Hospi n 24 hour ne Funeral	100	a constant	29a. Certifier (Check only one) 1 Certifying Ph	ysicien: To the best of liner. On the basis of and manner sta	examinati	rledge, death on andror inv	occurred at the tilestigation, in my o	me, date a opinion, de	nd place, an ath occurred	nd due to the ca	use(s) ate and	and manner as place, and due	stated. to the cause(s)	
To the To the Comp	12		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)											
, 1			D0063227 4/							11/1	106			
//			30. Name and address of son who completed cause of death (Itam 26) (Type, Print)  VIVGINIA C. Wiley 19 W. Frederick St Walkershill, MD 21793  31. Date filed (Month Arap Year) 3 2006  32. Resistrar's Signature											
	State		VIVGINIA C. 31. Date filed (Month Page Year)	When 32. Reistra	r's Signati	W. I	maoncr	. St	W	WKE SI	vill	1,00	ストナレン	
Regi			31. Date filed (Month Arap Year) 3	2006	ر معا	B 1	parte							
HMH 17 Rev	1/200	1				17								

DHMH 17 Rev 1/2001

06-02497 Lelia M. Kotula

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 0645 hrs Medical Examiner Lelia Matilda Kotula April 12, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 6042 Laurel Grove Road Denton Caroline 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 9 Rirthplace (State or **Funeral** Days Months Hours 214-28-3405 Director 1 M 2X F Oct. 11, 1929 76 Country) Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Caroline 1 Yes 2 Y No 28a-f show Denton notified at once hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 6042 Laurel Grove Road 21629 United States or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 Never Married 2 X Married Yes 2 X No Widowed Divorced Yes, Give Year 1 Yes 2 X No specify: Specify White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 l and Mental Hygiene is marked other than atic event, the Medical Agriculture/Poultry Farmer Baltimore, MD 21215-0036 10 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Anna Marie Wilson Be Arthur McCrackin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Matthews/Daughter 6532 Eldorado Rd., Federalsburg, MD 21632 Important: If item 27 njury or other trauma ges I and 2 of Health 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Junior Order Cemetery 04/17/06 Preston, Maryland ment Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee Framptom Funeral Home, P.A. Federalsburg, MD 21632 ode 216 N. Main St., Federalsburg, MD Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death a. Smoke inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). and Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery phy the b 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of the Hospital or Attending Physician: The law performed? death? certificate ] Yes 2 V No Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes No 28a. Date of Injury FOUND: After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject involved in housefire FOUND: 1 Natural 1 Yes 2 V No Pending Director: d in by the f 2 🗸 Accident Apr 12, 2006 0530 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 6042 Laurel Grove Road, Denton, MD determined (Specify) Farm/Ranch Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E. April 13, 2006 e of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Theodore King MD.

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Registrar's Signature

06-02496 John Kotula

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar Ce	ertificate of			Reg No. 2001	6 1346			
Physici edical Exami		Decedent's Name (First, Middle,Last)			Date of De.  Month	ath Day Year	3. Time of Death 0645 hrs			
Culcal Exami	IIIGI	John Kotula  4a. Facility Name (if not institution, give street and number)	4	o. City, Town, or Location	April 12,	2006 4c County of Dea				
		6042 Laurel Grove Road		Denton Caroline						
Funeral Director			last birthday) 78 Yrs.	If Under 1 Year If Und Months Days Hour	n Min	Fore	irthplace (State or ign <b>NJ</b> ountry) N. Jerse			
72 hours after death with the Maryland n "matural", or items 23a or 28a-f show any ral Examiner must be notified at once.		Usual Residence of Decedent  10a. State 10b. County 10c. City	y, Town or Location	n			10d. Inside City Limits			
	_	MD Caroline		1 Yes 2 XN						
	Director	MD Caroline Denton  10e. Street and Number 10f. Zip Code 11				10g Citizen of What Country?				
	D.	6042 Laurel Grove Road		21629		United Stat	tes			
n with ms 23 be no	uneral	11 Marital Status 12. Was Decedent Ever in U 1 Never Married 2 XMarried Armed Forces?	Decedent of Hispanic On			rican Indian, Black,				
r deatl	Fun	1 Yes 2 X No		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.  White						
rs afte ural",	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		Yes 2 X No specify s Usual Occupation (Give		Specify: 16b Kind of Business				
72 hou 1 "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of working life. DO NOT		Agricultui				
5-0036 led within 7 Hygiene other than	ldm	8								
ID 21215-0036 should be filed within 72 and Mental Hygiene 77 is marked other than matic event, the Medical	_	17. Father's Name (First, Middle, Last) Thomas Kotula			er's Name (First, Middle,	Maiden Surname)				
121 Id be 1 Mental narke event	o Be	19a. Informant's Name/Relationship (Type, Print )	19h Mailing	Address (Street and Nu	ry Socha	mhor City or Town Stat	o Zin Codo)			
Baltimore, MD 21215-0036  vernit. Pages I and 2 should be filed within 72 hours af Oppartment of Health and Mental Hygiene important: If item 27 is marked other than "natural nijury or other traumatic event, the Medical Examin		Deborah Matthews/Daughter	6532	Eldorado	Rd Fede	ralsburg.	MD 21632			
ore, MEss I and 2 so Health at If item 27			. Place of Disposit crematory or other	Eldorado	Date	20c. Location - City of	r Town, State			
mor Pages   nent of   nnt: If			unior C	rder Cem.						
Baltimo permit. Page Department o Important: injury or ott	1 3	27. Signature of Funeral Service Licensee	22. Na	me and Address of Facili	ty Framptom	Funeral	Home, P.A			
	0_0	23a. Part I. Enter the disease, or complications that caused the death	21	me and Address of Facili	t., Federal	sburg, MD 2	1632			
Physician /Medical		failure. List only one cause on each line.	n. Do not enter the	e mode or dying, such as	cardiac or respiratory ar	rest, snock, or neart	Approximate Interva Between Onset and Death			
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Smoke inhalation  Death  Due to (or as a consequence of):								
		Sequentially list conditions, b.								
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause, Enter Underlying Cause								
d Sit	xan	events resulting in death) Last Due to (or as a consequence of):								
wecute n and I - tran		UNPENDED X AMENDED Item 9 per FH,G856,06/27/06dhb								
760, Teate be ex physician the burial	/Medical	IF FEMALE: 23c. If yes, outcome of preg		,0050,00727		23d. Date of delive				
		23b. Was decedent pregnant in the past 12 months?	2 Feta	al death 3 Ectop	ic pregnancy		Day Year			
Sox 68 leath certifi e attending for use as t	Physiciar	4 Pregnant at time of de	ieath 5 Oth	er (Specify)		1				
ires that the dear signed by the a		Part II. Other significant conditions contributing to death but not n	resulting in the ur	derlying cause given in P	art I 23e. Did t	tobacco use contribute to	the cause of death?			
, <b>P.</b> ( res tha signed be det		1 Yes 2 No 3								
cords law requi	Completed			utopsy findings available						
Recc The lav	omp		ormed? death?	es 2 No						
	Be C	25 Was case referred to medical examiner?			(Check only one)					
F Vid Physic er this er	To	1 ✓ Yes 2 No	ER/Outpatient		Nursing Home 5	Residence 6 🗸 Othe	er; Scene			
n of rding Pl th : After e funeral	ion:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month Day Year) Apr 12, 2006	28b. Time of Inj 0509 hrs	ury 28c. Injury at Wor  1 Yes 2 ✓	Subject inv	how injury occurred olved in housefire				
Division of Vital Blospital or Attending Physician: 34 hours after death Funeral Director: After this certification of the funeral director,		2 Accident Investigation 28e, Place of Injury - At h	nome, farm, street			Street and Number or R	ural Route Number City			
Divis  Sepital or A hours after meral Dire y filled in b	Certification:	Suicide 6 Could not be determined (Specify) Farm/Range			or Town.					
e Hosp 24 ho e Func etely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.								
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated	and/or investigation				```			
	2	29b. Signature and title of certifier		29c License number	r	29d. Date signed (Me	onth, Day, Year)			
		Thirdle Mr Ky Land O.C.M.E. April 13, 2006								
		30. Name and address of person who completed of use of death (tren Theodore King MD. Assistant Medical Examine	,	n Street, Baltimore	, MD 21201					
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature								
Regis	trar	APR 1 7 2006	& Aco	28. 2						
DHMH 17 Rev 1/2	2001		ORIGINAL							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Loveless Thomas 11, 2006 Harry April 2:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing and Rehab. Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec 29, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**⊠**M 2□F Director 577-42-7986 80 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event. The Medical Examinar must be notified at 1 ☐ Yes 2 No Director Upper Marlboro MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 16711 Swanson Road USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iter 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: 3 XWidowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 mechanic state roads dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Elsie Gertrude Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16711 Swanson Rd., Upper Marlboro, MD 20774 Jeffery T. Loveless, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Dother (Specify) Ft. Lincoln Cemetery 04-14-2006 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Durumia /Medical Due to (or as a consequence of); Examiner Diseur A17HDi mers Sequentially list conditions, I any, leading to himsediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physician and use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant been signed by the atten should be detached for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 1. Derney X35206 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Livingston Road Fort WASHington MO. WILLIAM T. TANNER MY 11701 31. Date filed (Month, Day, Year) 32. Registras Signature State APR 1 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** APRIL 10  $\mathbf{P}^{\mathsf{M}}$ 2006 6:50 LINDA C. MCQUEENEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕱 F Yrs Director MAY 28, 1950 DC 216-58-8098 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No QUEEN ANNE'S MD STEVENSVILLE Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10 PETINOT COURT 21666 USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 X Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) TELEVISION STATION 12 MANAGER Pages 1 and 2 should be filed vinent of Health and Mental Hygie tant: If Item 27 is marked other taury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RICHARD CRAWFORD VIRGINIA NUNNELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 PETINOT COURT, STEVENSVILLE, MD JOHN T. MCQUEENEY, III/SON 21666 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER, LLC. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: If eny injury or once. 04/12/2006 STEVENSVILLE, MD 21. Signatur of Fyreral Syn ce Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications transcaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of bach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, page 2 should be 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2□ No 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be director 26. Place of Death | Check only one Hospitaf: Other: 2X No 1 Tyes 1 X Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D41816 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Soloman Island Rd. MD Pha 135 31. Date filed (Month, Day, Year) 32. Registrar's Signature Henry & Speake Registrar

DHMH 17 Rev 1/2001

		For State Of Marylar - State Of Marylar - State Amended 23a,4/13/06,LDB,DC 1. Decedent's Name (First, Middle, Last)	R Cer	tificate of I	Death	2. Date of De	Reg. No.		3. Time of Death	
Physici /Medio		James Patrick Malloy, Sr.					10, Day 2006	S ^{Year}	11:00 рм	
Examin		4a. Facility Name (If not institution, give street and number)  217 East Chew Ave.		4b. City, Town, or St. N	Location of D		4c. County	of Death		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 578-56-7203 12 M 2 F 61	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24		rth	9. Birthp	lace (State or Foreign ISylvania	
with the Maryland s or 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. C  Maryland Talbot	ty, Town or Loc	t. Michae	els			1	0d. Inside City Limits	
3a or 28a	Funeral Director	10e. Street and Number 217 East Chew Ave.		10f. Zip Code 216	563		10g. Citizen of V	g. Citizen of What Country?  USA		
within 72 hours after death with the Maryland ane. The nours after death with the Maryland ane. The nour naturel, or items 23e or 28e-f show then had a naturel to Maryland and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtheat and the mailtenance.	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in L Ammed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	spanic Origin n, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	Specify	e - Americ k, White,		
DESILITIOFE, INTERPLIATION Z. I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or any failury or other traumatic event, the Maded Examples.	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occupa kind of work done of DO NOT use retired Estimat		working	16b. Kind of Bu		dustry	
Tal ylailla 4 14.12. Italy within 2 should be filed within and Mental Hygiene. Is marked other then sumatic event, Italy.	To Be C	17. Father's Name (First, Middle, Last)  James Gerard Malloy			18. Mother's	Name (First, Middle y Jane Ja	, Maiden Suman			
1 and 2 sho Health and I tem 27 Is mu		19a. Informant's Name/Relationship (Type, Print)  Margaret Mary Malloy/Spouse	21	7 East Ch		r Rural Route Numb e., St. Mi	chaels,	MD	21663	
Pages 1 ment of H tant: If itel		1 Durial 2 Denantice 2 Denanticum State	dShoreC	remation(	Center	Date 4/12/2006		dge,	MD	
permit. Page Department of Important: If any injury or		11/Signature of Funeral Service Licensee	ell 2	Name and Address id Shore 272 Hudso	cremat Cremat on Rd.,	ion Cente Cambridg	er, P.O.	2 <mark>B</mark> 8¥3	1464,	
Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or complications that caused the dea shock or heart fartires. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	quence of):			EUMONIA	mest,		Approximate Interval Between Onset and Death	
<b>b8 / bU,</b> ificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	quence of):							
I RECOLUS, F.O. BOX 08/00,  The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	ery Day Year	
quires that n signed b	þ	Part II. Other significant conditions contributing to death but not re-	sulting in the un	derlying cause give	en in Part I.		tobacco use conti Yes 2 ☐ No	ibute to th	ne cause of death?	
The law requir	Completed					24a. Was auto perfo	psy prmed? g	Vere autoporior to con leath?	psy findings available npletion of cause of	
yelcien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?  Hospital:		Other		Death (Check only	one)			
ng Ph fiter th meral	tlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  1 Natural 5 Pending	28b. Time of Injury	28c. Injun Work	4 🗀 Nursir	28d. Describe	dence 6 Oth		/)	
ol or Attendi atter death. I Director: A	Certification:	3 ☐ Suicide 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At the building, etc. (Special Countries)	ome, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	l Route Number,	
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	e, date and p pinion, death o	ace, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s)	
To th withir To th comp	M	29b. Signature and title of certifier	MD	29c. License			29d. Date signed			
		30. Name and address of person who completed cause of death (Ite		Print)		Drive,	you all	/	- 06	

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylai		rtificate of		Re	g. No.	6   347
ŧ	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Robert	Н.		Mugge		2 Date of Death	11 ^{Day} 2008	3. Time of Death 2:45P. M
	Examin		4a. Facility Name (If not institution, give : Eden Homes, Inc.	street and number)			r Location of Death Spring		4c. County of I	Death tgomery
	Funeral Director		5. Social Security Number 6. Security 8695		last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, NOV - 28,	1921 F	Birthplace (State or Foreign County) 10r1da
	ow ow		Usual Residence of Decedent  10a. State 10b. County		ity, Town or L	ocation		*		10d. Inside City Limits
	8a-feh	ctor	Maryland Prince Ge	orge's	Silver	Spring				1 □Yes 2 No
	ath with the 123a or 2	Funeral Director	3128 Gracefield Ro	•		10f. Zip Code	20904		Og. Citizen of What United S	tates
036	be filed within 72 hours after death with the Maryland all Hygiene. Ist Hygiene. Includer then "neturel", or items 23a or 28a-f ehow of ther then "neturel", or items 23a or 28a-f ehow vent, Ira Madical Examinar must be notified at	þ	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1XX es 2 □ No If Yes, Give Year or Dates: WWI		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 27 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Decify Yes or No- Dican, etc.)		American Indian, White, etc. White
Baltimore, Maryland 21215-0036	within 72 ho Bne. then "netur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted)</i> College (1-4or 5+)		edent's Usual Occup e kind of work done DO NOT use retired & Welfare			16b. Kind of Busin Federal	ess/industry Government
land 2	be filed tal Hygi d other event, t	To Be Co	17. Father's Name (First, Middle, Last) August B. Mugge	J.	raction.			ne (First, Middle, M		
Mary	tnd 2 should lath and Men 27 is marks	8	19a. Informant's Name/Relationship (Ty Alma Elizabeth Mug		19b. Mail 3128	ing Address (Street Gracefie	and Number or Ru ld Road,#	ral Route Number. 523 Silv	City or Town, Sta er Sprin	nte, Zip Code) g,Maryland2090
imore,	permit. Pages 1 and Department of Health Importent: if item 27 eny injury or other to once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Me	Place of Disp cemetery, cre tropol	osition (Name of omatory or other place itan Crema	atory 4/1		20c. Location - Cit Alexandr	y or Town, State ia,Virginia
Balt	permit. Pa Departmen Importent: eny injury		21. Signature of Funeral Service License Word U. B.	reward						PA Maryland 20705
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the dea re cause on each line. Urinary Tra			ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						
	suted ansit	Examiner	Sequentially list conditions, if any, leading to immoviate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or se a conse	quanca of):					Ţ.
68760,	ificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conse	quence of):					
Вох	death certif e ettending id for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnancy	/		23d. Date o Month	
ds, P.O.	es the igned be de	d by Phy	Part II. Other significent conditions con Alzheimer's Diseas		sulting in the (	underlying cause giv	en in Part I.			ite to the cause of death?  ☐ Probably 4 ☐Unknown
Division of Vital Records,	The law requir sete has been si page 2 should	complete						24a. Was ar autops perform 1 Yes 2	24b. Wer y prio ged? dea 2 No 1	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	lospital:		ont 3C DOA Oth	or	th (Check only one	9)	
on of	ing Phys After this uneral di	llon; To	27. Manner of Death 1- Natural 5 □ Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur	4 🗀 140/3/119 11	ome 5 Reside 28d. Describe ho	nce 6 \( \sum \)Other (	semouphome
Division	of or Attend after death Director: / d in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, si		100 2 2 3 10	28f. Location (St. City or Town		or Rural Roule Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exemi	sicien: To the best of my kr ner: On the basis of examin and manner stated.	lowledge, dea lation and/or in	th occurred at the til	me, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	1/. 1	mony	29c. Licens D381		25	9d. Date signed (A	
,	10+1		30. Name and address of person who	empleted cause of death (Ite	om 23a) (Type	Priho		es es es es es es es es es es es es es e	April 1	
	/		Sita S. Krishnamoo	rthy, M.D. 12	2201 Pl	um Orchai	d Drive	Silver S	pring, Ma	aryland 20904
	Sta Registr		31. Date filed (Month Day, Year) APR 13 20	106 Server	H A	poels				

			For State Registrar	State of Ma		epartment of F Certificate of		Mental Hygie		13472
	• Physici	an	Decedent's Name (First, Middle,			- 1-		2. Date of Death	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, Picasant View	give street and number)	urtag ne ike		or Location of Deat	aryland	4c. County of Dea	
	Funeral Director		5. Social Security Number 579-58-7209		76 Yr	Months Days	If Under 24 Hrs	8. Date of Birth	9. Bir	rthplace (State or Foreign ountry) RELAND
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	the Ma 28a-f s	Director	MD. MONTGO	)MERY		TAKOMA PA	ARK	10a	Citizen of What Co	1 ∑Yes 2 □ No
	23s or		1400 ERISKI	NE ST.			20912		U.S.A	,
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23s or 28a-f show event, the Modical Eventhal rust be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? ed 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S.	<ol> <li>Was Decedent of I If Yes, specify Cub</li> <li>Yes 2 XNo</li> </ol>		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
215-0	hin 72 ho r. In "natur Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		(6	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of wo	orking 16t	o. Kind of Business	Andustry
12121	filed with Hygiene Sther the ent, the	Com	17. Father's Name (First, Middle, L	4	7	INSURANCE		me (First, Middle, Mai	GEICO	
aryland	should be filed withir and Mental Hygiene. It marked other than umatic event, the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Manage of the Mana	To Be	EDWARD	KENN	NEDY		10. 1410(110) 3 142	CATHERINE	BRENNA	N
Man	2 ar ar ar ar ar ar ar ar ar ar ar ar ar		19a. Informant's Name/Relationsh SHEILA WILLI	ip <i>(Type, Print)</i> AMS/DAUGHTER				ural Route Number, C.		Zip Code)
timore,			20a. Method of Disposition 1 ☐ Burial 2 XCremation		20b. Place of D	risposition (Name of crematory or other pla		The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	c. Location - City or	Town, State
altim	permit. Pages 1 a Department of Hea Important: If item any injury or othe		' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	pecify)	CHAMBEI	RS CREMATOR		17,2005 HOME & CRE	RIVERDA	
ä	Depart Import any in		121.21. Ch	anlessa	M0009	5801 CLEV	VELAND AV	E., RIVERD	DALE, MD.	20737
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each line	θ.	o PNEUN		c or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of)					Lean
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)					0.00
8760,	ate be executed sysician and he burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of)	:				
9	rtificate ing phys as the	Medical	IF FEMALE:	d						
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	Hivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significent condition	ns contributing to death bu		ne underlying cause gr	ven in Part I.	23e. Did tobac		o the cause of death?
Division of Vital Records,		Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Vita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	nt 2∏EB/Outo	atient 3 DOA	han /	ath (Check only one) Home 5 ☐ Residence	e 6 DOther (Sou	acifu)
ion of	ding Ph J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of Injury (Month, Day		ne of 28c. Inju		28d. Describe how i		July
Divis	Hospital or Attend 4 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could n 4 Homicide determine		ry - At home, farm . (Specify)	, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Ritate)	lural Route Number,
		edical (	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best of exeminer: On the basis of and manner stat	examination and/	death occurred at the ti or investigation, in my (	me, date and place opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as and place, and du	s stated. e to the cause(s)
)	To the within 2 To the complet		29b. Signature and title of certifler  N - J	relati		29c. Licens	30469	29d.	Date signed (Mont	th. Day, Year)
	3		30. Name and address of person v	who completed cause of de 8'850 CoCu	eath (Item 23a) (T	pe, Print) keway	4308	3, Colum	BIM, M	0.21045.
	Sta Registi	ite ar	31. Date filed (Month, Day, Year)							

			1 - For State Registrar	State of Ma	aryland		rtment tificate			Mental Hy	giene	006	13473
5	. 4	÷ -	1. Decedent's Name (First, Middle, La	st)						2. Date of De Month		Year	3. Time of Death
	Physicia /Medic		Herman Markovi	tz						April	8,	200	5 1:00 A₩
	Examin	*	4a. Facility Name (If not institution, give						ocation of Dea	ith		ounty of Deal	
			11307 Crescren	do Place					Spring			ontgom	ery
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. las		If Under Months	1 Year Days	If Under 24 Hr Hours Min	(Month D	av Ye <i>ar</i> )	l Cc	hplace (State or Foreign untry)
	Director		486-22-9674 Usual Residence of Decedent	X	83	3 Yrs.				Feb. 7	, 1923	Gze	chéslovakia
	and and		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mary feh	ō	Maryland Montgom	erv	Silv	ver Sp	rino						1 ☐ Yes 2 ☐ No
	the rotti	rec	10e. Street and Number	CLy	DII	ver br	10f. Zip	Code			10g. Citize	n of What Co	ountry?
	38 o	O E	11307 Crescrendo	Place			209	901			U. S	5. A.	
	deatl	Funeral Directo	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13. V	Was Deced	ent of His	panic Origin? (	Specify Yes or N into Rican, etc.)	0- 14	. Race - Ame Black, Whit	
0	after or Ite	E.	1 Never Married 2 Married	1 XYes 2 1	No	i	Yes 2		Specify:			pecify:	
0-00-c	72 hours after death with the Maryland naturel', or Items 23s or 28s-( ehow nical Exam, per must be notified at	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:				Λ					White
5	natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	lent's Usua kind of wor	l Occupat k done du	on ring most of w	orking	16b. Kind	l of Business	Industry
٧	withir	E G	Elementary/Secondary (0-12)	College (1-4ors			Lassi:					State 1	Department
7	filed within Hygiene. sther then "	e Co	17. Father's Name (First, Middle, Last,		·	- 0.	Labbi.			ame (First, Middle			ocpar emerie
yland	fental rked o	To Be	Nathaniel Mark					İ	Dora	Kohn			
<u></u>	shoul nd M mari	1	19a. Informant's Name/Relationship (			19b. Mailin	g Address	(Street an	d Number or F	Rural Route Numb	per, City or	Town, State,	Zip Code)
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Ie marked alther than "naturel", or Items 23a or 28a-1 e how eny Injury or other traumatic event, the Medical Examinar must be notified at once.		Lesley Markovi	tz - Son		4 Osı	rey (	Court	, Derwo	ood, Mar	yland	2085.	5
ā,	tem Item		20a. Method of Disposition	TD	20b. Pla	ce of Dispo	sition (Nam	ne of ther place		Date	20c. Loca	ation - City or	Town, State
Ĕ	Page nent contribution		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Jud	ean Me	em. Go	dns	4-1	1-2006	Olney	y, Mar	yland
baitimor	permit. Departm Importa eny Inju		21. Signature of Funeral Service Licer	nsee		E.d.	. Name an	d Address	of Eacility	al Direc	tion.	Inc.	
מ	8978		Donald (.	Stottles	nyer	100	1 Ro	ckwi1	1a Pik	e Rocky	ille.		and 20852
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the death.	Do not ente	er the mode	e of dying,	such as cardia	ac or respiratory	arrest,		Approximate Interval Between
۱ ا	Physician		Immediate Cause (Final disease or condition		brova								Onset and Death Years
	/Medical Examiner		resulting in death)	Due to (or as									
	LABITITIE	<b>L.</b>	Sequentially list conditions, b										
	ed str	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a conseque	ince or):							
	be executed ician and burial-translt	xan	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):							
2/0/0	ate be executed hysician and the burial-transit	icai		4									
00	death certificate e attending phys d for use as the			a.									
XOD	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7c:				23	d. Date of de	livery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant at			Ectopic pro Other (sp					Month	Day Year
;	w requires that lhe de been signed by the should be detached	hys	9 ☐ Unknown	9∐ Unknown									
ŝ	as tha	by F	Part II. Other significant conditions	contributing to death b	out not result	ting in the ur	nderlying ca	ause giver	in Part I.				the cause of death?
	equir en si ould								·	. 1	Yes 24	No 3 P	robably 4 []Unknown
ပ္သ	G 55 CA	Completed								24a. Wa auto	psy	prior to	atopsy findings available completion of cause of
<u> </u>	Page at	Cou								1 Yes	ormed? X□ No	death?	2 □ No
/Ital	sician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:						eath (Check only			
0	hys this	5	1 Yes 2 No 27. Manner of Death	1 Inpatie		PVOutpatien 28b. Time of		A Care	4 Nursing	Home 5 N Res			cify)
	15 e	io	1 TNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	M	8c. Injury : Work?	es 2 No	20d. Describe	riow injury	occurred	
DIVISION	Attending r death. ector: After by the fune	lical	3 ☐ Suicide 6 ☐ Could not b	e 290 Place of Ini	iury - At horr	ne. farm. str				28f. Location	(Street and	Number or R	ural Route Number,
2	al or Attendii atter death. I Director: A d in by the fu	Certification:	4 Homicide determined	building, et	ic. (Specify)		, , , , , ,			City or To	wn, State)		
	spita nours neral		29a. Certifier 1 X Certifying Pl	nysician: To the best	of my know	ledge, death	occurred.	at the time	, date and plac	ce, and due to the	e cause(s) a	nd manner a	s stated.
	To the Hospital or / within 24 hours atter To the Funeral Dire completely filled in b	Medical	(Check only 2 Medical Examone)	miner: On the basis o and manner st	of examination	on and/or in	vestigation,	, in my opi	nion, death oc	curred at the time	, date and p	lace, and du	e to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier				290	. License	number		29d. Date	signed (Mon	th, Day, Year)
			Brint A Bu	rger M				D378	340		Apri	1 10,	2006
	7		30. Name and address of person who										
	/		Dr. Brent Berg	er 10215			oad,	Suite	100,	Bethesda	, Mar	yland	20817
	Sta Registi		31. Date filed (Month, Day, Year) APR 13	2006 32. Registr	rar's Signatu	K A	andi)	9					
226	negisti	rai		2000	100 1	19							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			For State of Ma		epartment of Health Certificate of Death	h	giene 0 0 6	13474
	Physici		1. Decedent's Name (First, Middle, Last)			2. Date of De Month	Day / 2 Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, one street and number)	(In yrs. last birth Y	4b. City, Town, or Location  (day) If Under I Year If Under Months Days Hours	r 24 Hrs. 8. Date of Birt	4c. County of Death  (a / 2)  th (y Year) 9. Birth (7) (1918 M15)	
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Maryla f sho	tor	MD Howard		ott City			1 ☐ Yes 2 No
	th the or 28e anotif	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?
	ath wi	rai	8606 Beechnut Court		21043		United Sta	
920	be filed within 72 hours after death with the Maryland ital Hygiene. A cother than "natural", or Items 23e or 28e-f show event, the Modical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 XYes 2 N If Yes, Give Year or Dates:	0	<ul><li>13. Was Decedent of Hispanic Off Yes, specify Cuban, Mexical</li><li>1 ☐ Yes 2 No Specify</li></ul>	an, Puerto Rican, etc.)	Black, White	
5-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	1 (	Decedent's Usual Occupation Give kind of work done during mo	ost of working	16b. Kind of Business/I	ndustry
21215-0036	e filed within at Hygiene. other than event, the Man	Completed	Elementary/Secondary (0-12) College (1-4or 5-	+)	ife. DO NOT use retired) alesman		Furniture	
and	ould be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last)			her's Name <i>(First, Middl</i> e, ra Belle McC		
Maryland	2 should be and Menta is marked sumatic ev	၉	John Cowan McComb, Sr.  19a. Informant's Name/Relationship (Type, Print)	19b. '	Mailing Address (Street and Numi			ip Code)
	nd 2 Ilith a 27 is r trai		Barbara K. King/Daughter	83	54 Sunset Drive			
ore,	Pages 1 ar		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State		Disposition (Name of crematory or other place)	Date	20c. Location - City or	
Baltimore,			* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		Lawn Mem. Gard		Marriottsvi	
Ba	permit. Departn Importe any inju		I Dem Collins-Utthe	M01044	22. Name and Address of Faci	bia Pike Ell	licott City,	
Е			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line transdists. Cause (Final)	the death. Do no e.	1 ,		rrest,	Approximate fntervaf Between Onset and Death
	Physician /Medical			nary consequence of	Hrtery Di	sease		Years
	Examiner			,				
	ted	nlner	cause. Enter Underlying Cause (Disease or injury	consequence of	f):			
Ć	icate be executed physician and s the burial-transit	Examiner	that initiated events c	a consequence of	r):			
58760,	ate be hysicia lhe bu	edical	d					P. 1144
.O. Box 6	death certif e attending d for use as	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 0 9 □ Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliment	very Day Year
Δ.	26 D	by	Part II. Other significant conditions contributing to death bu	t not resulting in	the underlying cause given in Part	t I. 23e. Did to	obacco use contribute to	the cause of death?
Vital Records,		Completed				24a. Was autor perfo 1 ☐ Yes		topsy findings available ompletion of cause of
Vita	Physicien: T this certificat ral director, pr	Be	25. Was case referred to medical examiner?		0.1	ce of Death (Check only o		
of	Phys this ral di	ı; To	1	<del></del>	me of 28c. Injury at	Nursing Home 5 Resid	dence 6 Other (Spec	ify)
ion	토 중 등	atlor	2 ☐ Accident investigation	Year) Inj	jury Work? M 1 ☐ Yes 2 ☐	□No		
Division	af or Atte after de I Directo d in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Inju building, etc	ry - At home, farr . (Specify)	m, street, factory, office	28f. Location (5 City or Tov	Street and Number or Ru vn, State)	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and	death occurred at the time, date a /or investigation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th Withir To th comp	ž	29b. Signature and title of certified		29c. License number		29d. Date signed (Month	, Day, Year)
			· with 4 (a	mD	10005	8137	4/11/	2006
0	P		30. Name and address of person who completed cause of de	ath (Item 23a) (T	Sype, Print) er Aue St 3 Loane	07 woch	minster M	10 21157
	Sta	_	31. Date fifed (Month, Day, Year) 32. Pigistra	r's Signature		V-C711		
	Registr	ar	APR 1 4 2006	w K	Anare			

			For	Pleas					K. Ensure A Health and I	-		•	134.75
			1 - State Registrar				Cei	tificate of	Death		Reg. No		10410
	Physici /Medio		1. Decedent's Name Fr			ueller				2. Date of De	eath 15	, 20 <b>6</b> g	3. Time of Death 2: 45PM
Ž	Examir		4a. Facility Name (/	f not institution,	give street and nu	mber)		4b. City, Town,	or Location of Deatl	h	4c.	. County of Death	
				ubstati				Dento			1	Caroline	
	Funeral Director		5. Social Security N 491-26-2	450	i.Sex 1∭XM 2☐F	7. Age (In yrs 80	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi	rth 1925)	9. Birth Geri	place (State or Foreign ntry) Many
	Maryland -f show	tor	Usual Residence of 10a. State MD	10b. County Caroli	ne	10c. City Dent	y, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	th with the 23a or 28a	Funeral Director	10e. Street and Nur 27794 Su		n Road			10f. Zip Code 21629				nited St	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or itema 23a or 28a-f show other traumatic event, the Medical Exeminatment he collined at		11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		Armed Fo	edent Ever in U. prces? 2 No ve 1944 vates: 1946	1	Vas Decedent of l f Yes, specify Cub I ☐ Yes 2 1 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: Cau	etc.
21215-0036	within 72 ho lene. then "natur ne Medical	Completed by	(Spec		Education grade completed) College (1	1-4or 5+)	(Give life. l	lent's Usual Occu kind of work done OO NOT use retire	pation during most of wor ad)	king	16b. K	ind of Business/Ir	ndustry
and 2	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Mi	Be	17. Father's Name Frederick	(First, Middle, La		Mueller	шів		18. Mother's Nam		, Maiden		
Maryland	and 2 should saith and Men n 27 is marke	T ₀	19a. Informant's Na Mildred G					-	t and Number or Ru	ral Route Numb	er, City o		o Code)
Baltimore,	Pages 1 and 2 ment of Health . ant: If Item 27 i ury or other tra	Mildred G. Mueller/wife  20a. Method of Disposition  1 Substation Rd., Denton,  20a. Method of Disposition  1 Substation Rd., Denton,  20b. Place of Disposition (Name of cemetery, Crematory or other place)  20b. Place of Disposition (Name of cemetery)  20complexy, Crematory or other place)  20complexy, Crematory or other place)  20complexy, Crematory or other place)  20complexy, Crematory or other place)  20complexy, Crematory or other place)									20c. Location - City or Town, State Denton, MD		
Balt	permit. Pages Department of Important: If it any injury or once.		21. Signature of hu	Juneral Service, Licensee Moore Funeral Home, PA, 12 S. Second St.									1D 21629
J	Physician /Medical		23a. Part1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	Final	a the	aused the death each line.	MYD	er the mode of dyi	ng, such as cardiac	or respiratory a	arrest,	ION	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed XX is the law signed by the attending physician end XX is a should be detached for use as the burial-transit is	dicai Examiner	Sequentially list configure any, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death) L	nditions, imediate rlying injury iast	b. Due to	(or as a consequ	ENUI	VE CA	2010VAS	CULAR	918	2692	Chronic
P.O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live b	come of pregna wirth 2  Fetal mant at time of de pown	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of delive Month	ery Day Year
rds, P.	quires that the signed by ald be detacted.	þ	Part II. Other signif	icant condition	s contributing to de	eath but not resu	ulting in the ur	derlying cause gr	ven in Part I.		Yes 2		he cause of death?
		Completed	HYPE	RLEIPI	DEMH					24a. Was auto perfo		prior to co death?	opsy findings available impletion of cause of
/ita	ucian: Th certificate rector, pag	Be	25. Was case reference examiner?	red to medical	Marriagh	·		- 100	26. Place of Dea	th (Check only o	onel		
	ding Phys h. After this funeral di	tion: To	Yes 2 27. Manner of Death		28a. Date (Mont	Inpatient 2 🗍 of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wo	ner: 4 ☐ Nursing H ry at rk? Yes 2 ☐ No	ome 5 Resi 28d. Describe		6 □Other (Specification of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Cont	(y)
Division	To the Hospital or Attending within 24 hours after deeth.  To the Funeral Director: After completely filled in by the fune.	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	be 28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location ( City or To	Street an wn, State	nd Number or Rura )	al Route Number,
	To the Hospitai or A within 24 hours after To the Funerai Directompletely filled in by	edical C	29a. Certifier (Crieck only one)	1 Certifying 2 Medical Ex	aminer: On the ba	best of my know asis of examinat ner stated.	wledge, death ion and/or inv	occurred at the ti estigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as s d place, and due to	tated. o the cause(s)
	To the within To the comp	Me	29b. Signature and	15/101	Jen Sjen	MO.	DENUT	29c. Licens	4664	ر	29d. Dat	te signed (Month,	Day, Year) 2006
			30. Name and address R IS	TION E	no completed caus	e of death (Item	MD (Type, I	POBT	+6901	Denta	11	MD2	1629

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2006

			For State Registrar	State	of Marylar	•	artmen rtificat				lental Hyg	iene g. No.	06	13476	)
			1. Decedent's Name (First, Middle	, Last)							2. Date of Deat Month	h Day	Year	3. Time of Deat	ıth
	Physicia /Medic		ROBERT FRANKI	IN NINE							April	11	2006	5:55 1	$P^{M}$
	Examin		4a. Facility Name (If not institution	give street and no	ım <i>ber)</i>		4b. City,	Town, or	Location of	of Death		4c. Cou	inty of Death	1	
			Montgomery Hos	spice-Cas	ey Hous	e		ockv:				Moı	ntgome	ry	
	Funeral		5. Social Security Number	6. Sex 1 2 M 2 ☐ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Con	place (State or For untry)	reign
	Director		214.16.2101	TEATIVE Z	85	Yrs.					Aug. 2,	1920	Mar	yland	
	and w	ł	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Lin	mits
	daryl f • hc	ŏ	Manual and Manua			Silver	Cani	200						1 🖾 Yes 2 🗆	]No
	28a-	Directo	Maryland Montg	gomery		PITAGE	10f. Zip				10	0g. Citizen	of What Cou	untry?	
	3a or		417 Norwood Roa	ad			2	0905				U.S.	Α.		
	be filed within 72 hours after deeth with the Maryland Hyglane. Hyglane ad other than "natural", or items 23a or 28a-f ehow do other than "natural", or items 23a or 28a-f ehow event, the Medical Evaninar must be notified at	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Dece	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No-	14.1	Race - Amer		
۵	after or ite		1 ☐ Never Married 2 🔀 Marri		2 No WW	-					Rican, etc.)	]	Black, White <i>acify:</i> Wh		
2	rei', c	i by	3 Widowed 4 Divorced	If Yes, G Year or I	Dates: II		1 🗌 Yes	ZIXI NO	Specify:			Sp6	eciry: W11		
<u>ဂ</u>	72 h	Completed	15. Decedent (Specify only highes	's Education t grade completed	)	16a. Dece (Give	dent's Usua kind of wo DO NOT us	I Occupa rk done d	ation <i>luring</i> mos	t of work	ing	16b. Kind o	of Business/I	ndustry	
7	Athin ne.	ď	Elementary/Secondary (0-12)	College	(1-4or 5+)							n .1			
2	led w tygian her ti nt, th		7th 17. Father's Name (First, Middle, 1	Local		Gei	neral	Cont			(First, Middle, N		ding		
S S S	ntal Hed of	Be									Baxley		, allo,		
Ž	hould d Me mark matic	ဥ	Henry Frankli  19a, Informant's Name/Relationsl			19h Maili	na Address	(Street a			al Route Number,		wn State Z	in Code)	
<u>s</u>	d 2 s th an 17 is 1		Helen L. Nine/W					,			er Sprin	-			1
ē,	1 an Heel tem 2		20a. Method of Disposition	1110	20b. F	Place of Disno	osition (Nat	ne of					on - City or 1		-
ē	t: If I		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	cemetery, crei	matory of g	mete	ry 0	4/15	/2006 0	aklar	ıd. Ma	ryland	
Baltimore, Maryland 21215-0036	artme brtant injury		21. Signature of Funeral Service		50.							_			_
Ba	permit. Pages 1 and 2 should be file Dapartment of Health and Mental Hy Important: If Item 27 is marked to the any injury or other traumatic event ODGS.		Manan A	Vende	1	H 1	INES-	KINA New	LDI 1 Hamps	CUNER Shire	RAL HOME	, INC	Sprin	ng, MD 20	1904
			23a. Part1. Enter the dispase, or shock, or heart failule. List	complications that	caused the deal									Approximate Interval Between	
1	Physician		Immediate Canse (Final	_	monia									Onset and Death	ĥ
	/Medical		disease or condition resulting in death)	a	(or as a consec	quence of):								Days	
	Examiner														
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	juence of):									
	cutec nd transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	с											7
Ö,	ate be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to	(or as a consec	quence of):									- 11
8760	cate be executed physicien and the burial-transit	dicai		d											
9 ×	death certific e attending p ed for use as t	Physician/Me	IF FEMALE:	23c If yes o	utcome of pregn	ancy							D		
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1□Live	birth 2 Feta	al death 3	⊒Ectopic pi ⊒ Other (sp					23d.	Date of deli-	very Day Year	. 7
P.O.	0 00	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		3 <del>0</del> a(ii 3)	Other [st	ecity/							- 1
	The law requires thet the tab by the bas been signed by the bage 2 should be detached.		Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	underlying o	ause give	n in Part I		23e. Did tob	acco use	contribute to	the cause of death	1?
OS	uires sign td be	d by	Dementia								1 □ Ye	s 2 🔯 N	o 3□Pro	obably 4 Unkn	nown
Ö	w require been si should I	Completed									24a. Was a	n 2	4b. Were au	topsy findings avail	lable
æ	he lav e has age 2	шс									autops	ned?	death?	ompletion of cause 2□ No	∌ Of
ta		Be C	25. Was case referred to medical						26. Place	e of Deat	1 Yes 2		1 165	20140	
Division of Vital Records,	Attending Physician: r death. ector: After this certifict by the funeral director, I	ToB	examiner? 1 ☐ Yes 2 🖾 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DC	Othe	er: 4 □ Nu	ursing Ho	me 5 Reside	nce 6 🛭	Other (Spec	Hospi	Lce
0	ding Ph h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date	of Injury nth, Day Year)	28b. Time o	of 2	8c. Injury Work	at		28d. Describe ho	w injury oc	curred		
Ö	ath. or: Af he fur	atic	2 ☐ Accident investig	gation			М		Yes 2□	No					
<u> </u>	l or Atten efter deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could a determ	1286. Plac	e of Injury - At h	ome, farm, st	reet, factor	, office			28f. Location (St. City or Town		umber or Ru	ral Route Number,	
۵	pital or Atten burs efter deat leral Director: filled in by the														
	4 T S	edicai	(Check only 2 Medical	g Physician: To the Examiner: On the	basis of examina										
	To the Hos within 24 ho To the Fun completely	Med	one) 29b. Signature and title of certifier		nner stated.		200	License	number		- J-	Od Date si	aned (Mont)	n, Day, Year)	
	5 ¥ 5 0		255. Signature and the or certifier	1.											
	,		mere	Line	ne_	- 20-1/7		-424	52			Apr11	12,	2006	
	6		30. Name and address of person Chitra Rajago	11				11 R	load.	Rocl	kville.	Marv1	and 20	0850	
	Sta	te			gistrar's Sign	ature					,				
	Registr		31. Date filed (Month, Day, Year)	4 2006	10 an a	K A	borte	P							

		-	State of Maryland / Department of Health and Me State of Maryland / Department of Health and Me State of Maryland / Department of Health and Me Registrar Amend Item 26 per verb., G854 Officate of Beath	ental Hygien	e006  3477
				2. Date of Death	3. Time of Death
	Physicia /Medic		PHYLLIS MARILYN NEWMAN	PRIL 14	
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4	c. County of Death
			CIVISTA MEDICAL CENTER LA PLATA		CHARLES
	Funeral		Months Days Hours Min.	<ol> <li>Date of Birth (Month, Day, Yea</li> </ol>	9. Birthplace (State or Foreign Country)
	Director		220-56-8227 - 56	SEPT.3,	1949 WASH.,DC
	and *	-	Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location		10d. Inside City Limits
	Aaryk I sho	5	MINISTER SUIDENS		1 ☐ Yes 2 ☒ No
	28a-	Director	MARYLAND CHARLES INDIAN HEAD  10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Country?
	with				II C A
	leath	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	ify Yes or No-	14. Race - American Indian,
36	hin 72 hours after death with tha Maryland a. "natural", or items 23a or 28a-f show Medeal Examinational Denoifficed at	by Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto R  1 Never Married 2 Married 1 Yes 2 No If Yes, Sive 1 Yes X No Specify:  3 Widowed 4 Divorced Year or Dates:	ican, etc.)	Black, White, etc.  Specify: WHITE
Maryland 21215-0036	2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
715	in 72 in "nat	Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	0.	S. GOVERNMENT
212	ien jen th	E O	12 MANAGEMENT ANALYST	DE	PT. OF NAVY
פ	be filed tal Hygie d other event, II	Bec	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maid	en Sumame)
lar		2	GEORGE BEIGHEY FRANCIS	CECILI	A DIXON
an	s 1 and 2 should f Health and Men item 27 is marka othar treumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	Route Number, Cit	y or Town, State, Zip Code)
	1 and 2 Health em 27 i				N HEAD, NO. 20640
Baltimore,	es 1 ar of Hea of Hea fitem rotha		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20c.	Location - City or Town, State
Ĕ	permit. Pages Department of I Importent: if its any injury or or		'4 Donation 5 XOther (Specify) ENTOMBMENT TRINITY MEM. GDNS. 4-	-21-06 W	ALDORF, MARYLAND
alt	permit. Pag Department Importent: any injury c		21. Signature of Fugeral Service Licensee MOO4 9 RAYMOND FUNERAL		
<u>m</u>	89 5 8 9		Melalo. LA PLATA, MARVIA	ND 206	46
			23a. Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause of each fine.	respiratory arrest,	Approximate Interval Between
	Pnysician ₁		Immediate Cause (Final disease or condition resulting in death)  a	nepar	Monat an Death
	/Medical		resulting in death)  Due to (or as / consequence of):		
	Examiner		Sequentially list conditions, b.		
1	D #	ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause, Disease or injury		
	acuta and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of);		
30,	oe exection grant		Due to (of as a consequence of).		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	5.		
9	ertific ling p	Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box	leath certific attending p	Physician/Me	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month Day Year
0	the a	ysic	1 Yes No 9 Unknown 4 Pregnant at time of death 5 Other (specify)		
٥	that the de ed by the detached	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Records,	signe d be	d by		1 🗆 Yes	2 □ No Approbably 4 □Unknown
0	w requir been si should	Completed		24a. Was an	24b. Were autopsy findings available
}ec	elaw hast	ldm		autopsy	prior to completion of cause of death?
alF				1 □ Yes 2	No 1 Tyes 2 No
Vital	Physicien: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?  Hospital:   Descript   The FP/Outspiper   20 DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA Other:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTHER:   DOA OTH	./	0 Elothar (Operate)
of	Phys this	To.	To the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	8d. Describe how in	6 Other (Specify)
n	ling h. After fune	lo	1 Natural 5 Pending (Month, Day Year) Injury Work?  M 1 □ Yes 2 □ No		
Si	Attending or death. actor: After by the fune	cat	2 Accident Suicide 6 Could not be 280 Blood of Injury. At home farm street factory office.		and Number or Rural Route Number,
Division	or A after Dirac in by	Certification:	4 Homicide determined 256. Place of Injury Actionie, faith, street, factory, office building, etc. (Specify)	City or Town, St	rate)
-	the Hospital nin 24 hours a the Funerel I npletely fillad	0	29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a	nd due to the cause	e(s) and manner as stated.
	24 h 24 h Fur etely	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurre one)	ed at the time, date	and place, and due to the cause(s)
	To the Hospital or Attending Phwihin 24 hours after death. To the Funeral Diractor: After the completely filled in by the funeral	Me	29b. Signature and title of certification 29c. License number	29d.	Date signed (Month, Day, Year)
	⊢ ≤ ⊢ ŏ		X19431	4	4/14/06
	0		30 Name and (ddress of person who completed cause of death (Item 23a) (Type, Print)		11 1100
	0		Track M Ryalm 11701 LIVINGUES # 100	77. Mg	My 100 MD 20144
	Sta	ite	31. Date filed (Month, Pay, Year) 32. Registrar's Signature		· · · · · · · · · · · · · · · · · · ·
	Regist		APR 2 7 2006		

				State of M						-		_	Die.	I are I have	
			1 - For State Registrar		a. y (a.				Death	, , , , , , , , , , , , , , , , , , ,	Reg. N	4 U U	6	134/	8
			Decedent's Name (First, Middle, L.	ast)						2. Date of	Death			3. Time of Dea	ath
	Physicia /Medic		Norma Sandra Pat	tison						APRI		O Z	Year	1500	М
	Examin		4a. Facility Name (If not institution, g		,	1	4b. City	, Town, o	r Location of Dea			c. County	of Death		
			DORCHESTE			OSPITA	4		MBRI				1465		
	Funeral		,	Sex 7. Ag		last birthday Yrs.	) If Unde Months	Days	If Under 24 Hrs Hours Min	(Month,	Birth Day, Yea	r)	9. Birthpl Coun	ace (State or Fo	reign
	Director		215-38-0190 Usual Residence of Decedent		65	113.				March	4,1	941	Mary.	Land	
1	yiend		10a. State 10b. County		10c. Ci	ity, Town or L	ocation						10	Od. Inside City Li	
5	e-f st	ctor	Maryland Dorchest	ter	Eas	t New	Marke	et						1 ☐ Yes 2 💆	ΩNo
3	or 28	Director	10e. Street and Number				10f. Zi	p Code			10g. C	itizen of V	Vhat Coun	try?	
80	ath w		5965 Heritage Ro					631				USA			
Ma	er de Kame	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		J.S. 13.	Was Dece If Yes, spe	edent of H ecify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or to Rican, etc.)	No-		e - America k, White, e		
36	rs aft	by F	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🕅 If Yes, Give Year or Dates:	NO		1 🗆 Yes	2 🛛 No	Specify:			Specify	" Whi	te	
Ö	within 72 hours after death with the Marylend Jiene. rthen "naturel", or Iteme 23a or 28e-f show Ite Medicel Examiner must be notified at		15. Decedent's	Education		16a. Dece	edent's Usu	ual Occup	ation		16b.	Kind of Bu	siness/Ind	lustry	
215	thin 7 e. en "n	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired	ation during most of wo d)	rking					
21	e filed within al Hygiene. other then vent, I've Ma	Completed	12			Owne	r/Ope	rato					e Mal	.1	
pug		Be	17. Father's Name (First, Middle, Last Norman Elsworth		r				18. Mother's Na	me (First, Midd ha Loue			· ·		
ž	should be ind Mental marked o	ပ	19a. Informant's Name/Relationship		т •	19h Mail	lina Addres	c (Street	and Number or R					Codel	
Ma	O1 02 00 00		William H. Patti		đ		•		Road, Ea						
ō,	of Health of Health litem 27		20a. Method of Disposition	SOII/ Hasbair	20b. I	Place of Disp	osition (Na	ame of	Ţ	Date	1		City or To		
ē	Pages nent of B nnt: If ite		1 ☐ Burial 2 🛣 Cremation 3  `4 ☐ Donation _5, ☐ Other (Spec			cemetery, cre natory		·		2/2006	De l	lmar.	Dela	ware	
Baltimore, Maryland 21215-0036	그 두 본 등		21. Signature of Furgeral Service Lic		11				ss of Facility eral Hom						
m	permi Depar Impoi any Ir		Benevel (	J. Del	121	1	06 Ma	iin S	treet, E	ast Nev	7 Mar	ket,	MD 2	1631	
		4	23a. Part . Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each li	the dea	th. Do not er	nter the ma	de of dyin	ig, such as cardia	c or respiratory	arrest,			Approximate Interval Between Onset and Deat	ņ
	Physician		Immediate Cause (Final disease or condition	-a /revi	nor	ria							10	days	11
	/Medical Examiner		resulting in death)	Due to (or as	1		1		0				7	VI	N.
		-	Sequentially list conditions,	b. Due to (or as		gence of):	nu	1079	Cance	7			7.	non ru	5
	uted I ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
ć	le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as	a consec	quence of):									
760,		cal		d											
89	leath certificate attending phy I for use as the	Physiclan/Med	IF FEMALE:												
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fet	el death 3	□Ect <i>o</i> pic p		,			23d. Dat	e of delive	ry Day Year	
	at the dea by the a tached fi	ysic	1 ☐ Yes 2(☐ No 9 ☐ Unknows	4□Pregnant a 9□ Unknown	t time of o	death 5	Other (s	specify)			-			,	
P.O.	res that the signed by be detact		Part II. Other significant conditions	contributing to death b	ut not res	sulting in the	underlying	cause giv	en in Part I.	23e. Di	d tobacco	use contr	ribute to th	e cause of death	1?
Sp	uires sign lid be	d by	Prin met	istases						A	Yes	2 🗆 No	3 Proba	ably 4 □Unkn	10WN
00	w require been signatured should b	Completed	(7,-,-,-,-,-							24a. W	as an	24b. V	Vere autop	sy findings avail	lable
Re	The tav	mo								au pe 1 ☐ Yes	topsy normed?	C	death?	npletion of cause 2010	e of
ita	sician: The la s certificate ha lirector, page 2	a	25. Was case referred to medical						26. Place of De			10   1	165	<b>2</b> -140	
>	Physici this ce al direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: Inpatie	ent 2	] ER/Outpatie	ent 3 D	OA Oth	er: 4 🗆 Nursing I	Home 5□Re	sidence	6 Othe	er (Specity	)	
0	ng Ph (fter th		27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time Injury		28c. Injun Wor	k?	28d. Describ	e how inj	ury occurr	ed		
Sio	Attanding Physician: The law requires that the death certifica ri death. It death. ector: Atter this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the c	cat	2 Accident investigate 3 Suicide 6 Could not	he	44.6		М		Yes 2 □No	ORE Leasting	/Ct-===	and Missesh		Contraction of the second	
Division of Vital Records,	or At after of Direct in by	Certification:	4 ☐ Homicide determine				treet, facto	ry, <i>a</i> ttice			own, Sta		er or Hural	Route Number,	
_	To the Hoepitel or within 24 hours after To the Funerel Dir completely filled in	C	29a. Certifier Certifying	Physician: To the best	of my kn	owiedge, dea	th occurred	at the tin	ne, date and plac	e, and due to the	ne cause(	s) and ma	nner as sta	ated.	
	s Ho	edical	(Check only 2 Medicel Ex	aminer: On the basis of and manner st	f examina	ation and/or i	nvestigatio	n, in my o	pinion, death occ	urred at the tim	e, date a	nd place, a	and due to	the cause(s)	
	To the Hospitel or Attanding F within 24 hours after death.  To the Funerel Director: After completely filled in by the funer.	Me	29b. Signature and title of certifier				29	c. Licens	e number		29d. D	ate signed	Month, I	Day, Year)	
			regine 1	que a	>>			451	793		7	119	06		
			30 Name and address of merson wh	o completed cause of c	leath (Ite	m 23a) (Type	, Print)	1	+ 1	1	1	mi	2 2	11.10	
			31. Date filed (Month, Day, Year)	32. Registr	ar's Sign	ature	1741	カラ	/ Car	mpric	130	11	a CA	415	
	Sta Registr		APR 1	2006	A.a.	K	Boise	161							

		1 - For State Registrar	State of Maryland / D	Department of F Certificate of I	lealth and N <i>Death</i>		ene () () ()	3479
		1. Decedent's Name (First, Middle, Last)	***			2. Date of Death	Day Van	3. Time of Death
Physic /Med		William H. Pepper				Month April 1	Day Yea 2006	6:30 A ^M
Exam		4a. Facility Name (If not institution, give s	reet and number)	4b. City, Town, o	r Location of Death	1101 11 1	4c. County of De	
LAGIII		D 1 17		D-4			Mam	
Funera		Rebecca House  5. Social Security Number 6. Sex	7. Age (In yrs. last bin	thday) If Under 1 Year	omac If Under 24 Hrs.	8. Date of Birth	9. E	tgomery  Birthplace (State or Foreign
Directo		084-18-9060	M 2□F 80	Yrs. Months Days	Hours Min.	(Month, Day, ) Apr 28,	rear)	Country) ew York
	4	Usual Residence of Decedent	80		1	Apr 20,	1923 N	ew IOIK
land ow		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Mary Herb	ō	Marriand Mantagers	ry Bethes	, do				1 ☐ Yes 2 No
1he 286	Director	Maryland Montgome  10e. Street and Number	ry bethes	10f. Zip Code		100	g. Citizen of What	Country?
with					_			
be filed within 72 hours after death with the Maryland tate hygiene then "naturel", or Iteme 23a or 28e-f ehow event, it a Mudical Exertinar must be poulfied at	Funeral	7705 Hemlock St	2. Was Decedent Ever in U.S.	2081		porfu Voc or No	USA	mencan Indian.
er de	S	11. Marital Status 1 1 ☐ Never Married 2 ☐ Married	Armed Forces?	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, W	
d within 72 hours aft giene. or then "nature!, or the Medical Exam	by F	3 ☐ Widowed 4 ☐ Divorced	1 ZAYes 2 □ No If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 🗓 No	Specify:		Specify:	
urel								White
72 nat	Completed	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occup (Give kind of work done)	during most of work	ing 16	6b. Kind of Busines	ss/Industry
ji je je ji	ద	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retired	1)			
Hygier ti	S		5+ 5	Systems Anal				ent of the Ar
tal H	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
Ment	ပို	Louis Pepper			Flore	ice Pech		
and and	114	19a. Informant's Name/Relationship (Typ	e, Print) 19b.	Mailing Address (Street	and Number or Rur	al Route Number, 0	City or Town, State	e, Zip Code)
permit. Pages 1 and 2 should be in Department of Health and Mental Importent: If Item 27 is marked on eny injury or other traumatic events.		Marian Pepper/Wife	7	705 Hemlock	St. Beth	nesda. MD	20817	
rmit. Pages 1 are partment of Hee portent: If Item y injury or othe		20a. Method of Disposition	20b. Place of	Disposition (Name of			oc. Location - City	or Town, State
age ut o	U	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	y, crematory or other place	1		D 1 4	
rten njun		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Liceose		ah Gardens		16, 2005	Rockvii	
Depar Impo		21. Signature of Purietal Service Liganiza	000	22. Name and Addres				
40200		, caa c	James					ing, MD 20904
Physiciar /Medica		23a. Part1. Enter the disease or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		gestive hear				Approximate Interval Between Onset and Death
Examine	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	al fibrilla	tion			3 mos
icate be executed physicien and s the burlat-transit	Examin	Cause (Disease or injury that initiated events		ntia				
e exe en a ırlal-	m	resulting in death) Last	Due to (or as a consequence of	of):				
te be	dicai	d						
tifica g ph as th	1 0							
death certific e attending p ed for use as	Physician/M	IF FEMALE: 23 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy	2 🗆 🗆			23d. Date of c	delivery
deatl	Cia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
t y the	S	9 □Unknown	9□ Unknown					
requires that the de een signed by the a hould be detached f		Part II. Other significant conditions con-	ributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
sigr d be	d by					1 ☐ Yes	2 ¹ No 3□	Probably 4 □Unknown
req nou	ompieted					146	Table Market	
E S C	id					24a. Was an autopsy	prior t	autopsy findings available of completion of cause of
Page 1	ပ်					performe	ad? death Mano 1 ☐ Y	es 2□ No
Physician: Th this certificete rat director, pag	Be (	25. Was case referred to medical examiner?			26. Place of Deat	h (Check anly one)		
nysic dire	2	1 ☐ Yes 2 🗓 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Oth	er: 4 Nursing Ho	me 5 Residen	ce 6 □Other (S	pecify)
g Pt er th ieral		27. Manner of Death		ime of 28c. Injury		28d. Describe how		
Attending it death.	1 Sign	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day (Gal)		Yes 2 □No			
Atte	100	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, fa	rm, street, factory, office				Rural Route Number,
To the Hospitel or Attending Physwithin 24 hours eller death.  To the Funerel Director: Afler this completely filled in by the funeral di	Certification:	4 Homicide	building, etc. (Specify)	,,		City or Town,		
pite ours erei		29a. Certifier 1 X Certifying Phys	cian: To the best of my knowledge	death provided at the ti-	no date and slass	and due to the e-	ca/c\ and m ===	as stated
Hos 24 hc Fun tely	edicai	(Check only 2 Medical Examin	er: On the basis of examination and	d/or investigation, in my o	pinion, death occur	red at the time, date	e and place, and d	ue to the cause(s)
To the within 2 To the complet	Med		and manner stated.	200 Lieser	a number	1.00	Data signed (14)	onth Day Vassi
7 ¥i v		29b. Signature and title of certifier	Ja Vilu.	29c. License	e number	290	I. Date signed (Mo	nno, Day, Year)
		, 401	any of	D0	041072	A ₁	pril 12,	2006
20		30. Name and address of person who con	npleted cause of death (Item 23a) (	Type, Print)		•		
000		Azhar Manipady, MD	10810 Connecti	cut Ave. Ke	nsington.	MD 2089	5	
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	barte				
Regis		APR 14	2006 Malere At	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) April 11, Day **Physician** Dorothy Clarke Perpich 2006 12:32 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 217-18-8483 1 □ M 2 🖾 F 84 Director 25, 1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Types 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other than "natural", or itame 23a or 11411 Traville Garden Circle, #111 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 A Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home of Heelth and Mental Hygie filtem 27 is marked other in other traumatic event, it permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important; if Item 27 is marked oth any njury or other traumatic event, socie. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Clarke Louise Hayden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul P. Perpich/ Husband 11411 Traville Garden Circle, #111 Rockville, MD 20b. Place of Disposition (Name of April 18, 20c. Location - City or Town, State 20a. Method of Disposition St. John's Parish 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Hollywood, Maryland Church Cemetery O 21. Signature of Funeral Service Censee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a confequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably should I 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cete has t autopsy performac Yes 2.4 this certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After the 27. Manner of Death

1 A Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours after To the Funeral Direcompletely filled in b Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the gausa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062653 April, 11, 2006 rson who completed cause of death (Item 23a) (Type, Print) RYAN HOLMES, M.D., 9901 Medical Center Drive, Rockville, MD 20850 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2:15 РМ Mary Jane Pajak April 18, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 84 Director 123-12-5561 October 23,1921 New York Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28e-f show the Medical Exeminar must be notified at 1 ☐ Yes 2 No Director St. Mary's Lexington Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21646 Forest Park Road 20653 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If fem 27 is marked other them." 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2√XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛱 No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Ignatius Lewicki Catherine Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. <u>Pajak / Son</u> 21646 Forest Park Road, Lexington Park, Maryland 20653 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State April 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hollywood, Maryland 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mona disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner gestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit ena Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 € No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nellits 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2€☐ No 24a. Was an s certificate has blirector, page 2 s performed No 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Mapner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R / TH B. JHHVER 7, M.D. 22335 F 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Kita

B.

32. Registrar's Signature

ORIGINAL

29c. License number

8003265

22335 Exploration Drive, Lexington Park, Maryland 20653

29d. Date signed (Month, Day, Year)

06 -

Registrar

Hailey Marie Pike

			1- State of Maryland / Department of Health and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth and Mealth	ental Hygier	000	13482
	" n , 122°		Decedent's Name (First, Middle, Last)	2. Date of Death	ay Year	3. Time of Death
	Physici /Medio			April 17,	2006	10:00PM M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  City is the Modified Contact  LaDiana		Charat	h
	Funeral		Civista Medical Center LaPlata  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Charles 9. Bird	hptace (State or Foreign
57	Director		N/A 1□ M 2XF Yrs. Months Days Hours Min.	(Month, Day, Year 04/17/2	r)   Co.	aryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryl f sho	to	MD Calvert Huntingtown			1 XYes 2 □ No
	h the	Director	10e. Street and Number J 10f. Zip Code	10g. (	Citizen of What Co	untry?
	23a o	alD	1930 Solomons Island Road 20639	Un	ited St	cdes
	er dea	Funeral	11. Maritat Status NA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri	rfy Yes or No- ican, etc.)	14. Race - Ame Black, White	
39	urs aft	by F	1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify:		Specify: W	hite
2-0036	72 hours after death with the Maryland naturel', or Itema 23a or 28e-f show dical Exem. Included by		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	Kind of Business/l	
2121	nithin ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		.\ ^	
22	filed within Hygiene. Ither then "	S	NIA NIA NIA 17. Father's Name (First, Middle, Last)	First Middle Maid	JIA Sumama)	
Maryland	ed ta b	To Be				Hudson
ary	should and Men marke umatic	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural in the Information of Paral in the Information of Paral in the Information of Paral in the Information of Paral in the Information of Paral in the Information of Paral in the Information of Paral in the Information of Paral in the Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of Paral Information of			
	and 2 Balth a n 27 le		Dawn Lena Marie Pike / Mother 1930 Solomons Island Rd.	Hunting	town, MD.	20639
more,	Pages 1 nent of He int: If iter iny or oth		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	200.	Location - City or	
=	rtmen rtant: njury	1	4 □ Donation 5 □ Other (Specify) Immaculate Heart Cem 04/22  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Posts	2/2006 Lex	kington F	Park, MD.
Ba	permit. Departr In portu er y inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bring Kyle S. Simons M01206 22955 Hollywood Rd.	isfield Fu	ineral Ho	ome PA.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		wii, mary	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition		x train	Onset and Death
100	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	J. Jean		
		e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
o,	e exection and an arrial-tr		resulting in death) Last  Due to (or as a consequence of):			
68760	ficate be executed physicien and is the burial-transit	edical	d			
_			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delin	vos.
. Box	death e etter	Physician/M	in the past 12 months?  1		Month Month	Day Year
P.O.	et the	hys	9 Unknown			
	The law requires thet the death cert ate has been signed by the ettending page 2 should be detached for use a	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		a 1	the cause of death?
Ö	w require	eted		-	(0 -	obably 4 Unknown
Division of Vital Records,	: The law cate has page 2 s	Completed		24a. Was an autopsy performed?	prior to c death?	topsy findings available ompletion of cause of
ta		Be Co	25. Was case referred to medical 26. Place of Death (	Check only one	o 1 🗆 Yes	21 No
<u> </u>	hysici nis cer I direc	10 B	Hospital: 3	5 🗆 Residence	6 ☐Other (Spec	ıfy)
n 0	nding Physicien: th. : After this certifica funeral director, p		1 Natural 5 Pending (Month, Day Year) Injury Work?	d. Describe how in	ury occurred	
S	tor the	Icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined 28e. Place of Injury. At home, farm, street, factory, office 28	f. Location (Street a	and Number or Du	m I Courte Alventos
2	el or A after I Direct d in by	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town, Sta	(e)	rai noute ivamber,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only check only check)  (Check only check)  (Check only check)  (Check only check)	d due to the cause(	s) and manner as	stated.
	To the H within 24 To the F complete	Medi	and manner stated.			
	T W		29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month	10 10 CO
			30. Name and address of person wito completed cause of death (flem 23a) (Type, Print)			IDIAN
			Makonnen K Zelleke Medical Staff Services 170 Southport	Dr Morri	sville N	C 27560
ないのかの	Sta Registr	_	APR 2 1 2006 APR 2 1 2006			

			1 - For State Registrar	State of Ma		epartment of F Certificate of		_	ene g. No. 0 0 (	13483
П	Physici	an	1. Decedent's Name (First, Middle, La	ast)				2. Date of Death Month	Day Yea	3. Time of Death
	/Medic		Mariano Ristaino					April	7 2006	2:45 P M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of De	
			Anne Arundel Med: 5. Social Security Number 6.3		C e (In yrs. last birtho	dav) If Under 1 Year	Annapol:			rundel
	Funeral Director			1 <u>M</u> 2 □ F	94 Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 8,	Ye <i>ar)</i> 1911 N	Birthplace (State or Foreign Country) Iew Jersey
			Usual Residence of Decedent					bury o,	וופו	lew Dersey
	e Marylan ie-f show	ctor	Maryland Anne A	Arundel	10c. City, Town o		polis			10d. Inside City Limits 11√2√4°es 2 □ No
	th with th	al Dire	10e. Street and Number 670 Americana Dri	ive, Apt. 2	27	10f. Zip Code	21403	10	g. Citizen of What U.S.	•
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel; or Items 23a or 28e-f show other treumatic event, Ite Modical Evarines must be notified and other treumatic event, Ite Modical	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	Ever in U.S. No 1945–46	13. Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2☑ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc. White
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. D	ecedent's Usual Occup Give kind of work done	pation	1	6b. Kind of Busine	ss/Industry
7	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5		ife. DO NOT use retire	d)	,,g		
2	e filed within al Hygiene. I other than ' vent, Inc Mu		10 17. Father's Name (First, Middle, Last	N1		Planner	10 14-15-1-11	(First Add date Ad	U.S. Gov	ernment
Maryland 21215-0036	should be fi and Mental H s marked ot umatic ever	To Be	Carmine Ristain	)				enza Alv	ino	
Mar	12 sh h and 7 is rr treum		19a. Informant's Name/Relationship Elizabeth Bernst			Mailing Address (Street 00 Warren				
e,	1 and Health tem 27	13	20a. Method of Disposition	cerri, daugri		isposition (Name of	and the second second	-	Oc. Location - City	
Por	m 0		1 Burial 2 ☐ Cremation 3		cemetery,	crematory or other pla	ce)			, Maryland
Baltimore,	근 한 '문	1	* 4 ☐ Donation 5 ☐ Other (Special Signatur → Fireral Servic, Lice		1-1	22. Name and Addre				
Ba	permi Depa Impo any io		) Todal	E R	lles	147 Duke o	f Gloucest	er St.,	Annapoli	s, MD 21401
ı	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each in	MONIA		ng, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death 3 WEEKS
	/Medical Examiner		1000ming in doding	Due to (or as	a consequence of)	:				
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	b. — Due to (or as	a consequence of)	:				
8760,	ate be executed hysician and the burial-transit	Ical	that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	:				
P.O. Box 60	Attending Physicien: The law requires that the death certifica erdeath. erdeath. by the funer this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) □	(		23d. Date of o	delivery Day Year
rds, P.	w requires that been signed by should be deta	ed by Ph	Part II, Other significant conditions of	CARDION			ren in Part I.	23e. Did toba		to the cause of death?
Division of Vital Records,	ysicien: The law re is certificate has bee director, page 2 sho	Completed by				1		24a. Was an autopsy perform	24b. Were prior to death?	autopsy findings available ocompletion of cause of ?
/ita	icien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death		-	
<u></u>	Physic this o	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie			4   Iduising Hon	ne 5 🗆 Residen	ce 6 □Other (Sp	pecify)
ion	anding Poath. or: After the funera	atlon:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigatio		y 28b. Tim Year) Inju	ry Wor	yat k? Yes 2 □ No	28d. Describe how	r injury occurred	
DİX	tel or Atters al Directored in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm c. (Specify)	, street, factory, office	2	28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one)  Certifying Pl	nysician: To the best on miner: On the basis of and manner sta	examination and/o	eath occurred at the tire or investigation, in my o	me, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	11	-	29c. Licens			d. Date signed (Mo.	
	And the second second		1 /3m (will	llace Mr.	)	D3.	1136	A	PRIL 11,	2006
			30. Name and address of person who ISKIAN C- WA	LIACE MU	eath (Item 23a) (Ty			ALTIMOR	E, MA	21236
	Sta Registr		31. Date filed (Month, Day, Year)  APR 12		ar's Signature	bod				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		State of Ma	aryland /		rtment of Ho tificate of D		Mental Hy	rgiene Reg. No.	UU6	13484
Dhusis	ion	1. Decedent's Name (Fi							2. Date of De Month	Day	Year	3. Time of Death
Physic /Med		AIIICU I.		•					April	08	2006	9:08 P M
Exami	iner		-	street and number)			4b. City, Town, or	Location of Deat	n		County of Death	
F		527 Bay St 5. Social Security Numb		x 7. Age	(In yrs. last b	irthday)	Berlin If Under 1 Year	If Under 24 Hrs		rth	Worceste 9. Birth	place (State or Foreign ntry)
Funeral Director	_	216-14-2451		<b>X</b> M 2□ F	99	Yrs.	Months Days	Hours Min.	July 2		906	MD
pu k		Usual Residence of Dec	b. County		10c. City, To	wn or Loc	cation					10d. Inside City Limits
Aaryla I shor	2		Worcest	er	Berli							1 □XYes 2 □ No
28a-	100	10e. Street and Number		<u> </u>	10.111	11	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
h with	Funeral Director	527 Bay St	reet				21811				U.S.A	4.
ems	IDA	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. W	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or Note Rican, etc.)	0- 1	<ol> <li>Race - Ameri Black, White,</li> </ol>	
s afte	hv F	1 ☐ Never Married 3 🖾 Widowed 4 ☐		1 XYes 2 ☐ N If Yes, Give Year or Dates:	₀ Navy	1	☐ Yes 2☑ No	Specify:			Specify: Bla	ack
ie, interly identified a 12.12.10000  I and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Modical Executer must be rotified at			Decedent's Ed	ucation	16	a. Deced	ent's Usual Occupa	tion	-t-'	16b. Kir	nd of Business/Ir	ndustry
Pin 72	Completed	(Specify of Elementary/Secondary	only highest grad ry (0-12)	de completed) College (1-4or 5	+)	life. D	kind of work done d OO NOT use retired)	uring most of wo	rking			
ed will ygien ygien t, the	2	8th					Labo		en Cient Mintelli	A faida s	Lumber	
be fill H ad off	a	1						Louise	me (First, Middle	s, maiden	Sumame)	
and Mei and Mei Is mark	1	19a. Informant's Name		vpe, Print)	19	b. Mailin	g Address (Street a			ber, City or	Town, State, Zi	p Code)
d d d d d d d d d d d d d d d d d d d		Mable Jarm		•	1	18 B	ranch St.	, Berli	n, MD 21	811		
te, IV		20a. Method of Disposit	tion		20b. Place	of Dispos	sition (Name of natory or other place S Cemeter		Date	20c. Lo	cation - City or T	
Page nent c ent: If ury or		1 Surial 2 ☐C	remation 3 ∐ Other (Specify	Removal from State	St. P	auı'	s Cemeter	y 4/1	5/2006	Bei	rlin, MI	)
Defilition of permit. Pages 1 and Department of Heall Importent: If Item 2 any injury or other any	Ė	21. Signature of Funera		I for 1		L	Name and Addres	atson Fi	uneral H	iome		
		23a. Part1. Enter the d	sector	Valsory	I the death Dr	1 1	618 West	Rd., Sa.	lisbury,	MD 2	21801	Approximate
		shock, or heart fa	illure. List only	one cause on each iii	10.							Interval Between Onset and Death
Physiciar /Medica		disease or condition resulting in death)	-		a consequence		queid	ent				
Examine	r			b .								
<b>₽</b> ≅	9	Sequentially list condition in any, leading to imme cause. Enter Underlyin Cause (Disease or inju	diale 📆	Due to (or as	а вопажувала	e ofly.						
ecuter and -trans	Evaminar	Cause (Disease or injue that initiated events resulting in death) Last		C. Due to for as	a consequenc	e of):					_	
ficate be executed physician and is the burial-transit	ú				2 00/130400/10	0 017.					1	
ficate ficate physics the	lecito			. d								
us, F.O. BOX or nires that the death certific signed by the attending p d be detached for use as	Dhucician/M	IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, outcome 1□Live birth		th 3	Ectopic pregnancy			2	23d. Date of deliv	•
death death ne atte	01010	in the past 12 mo 1 ☐ Yes 2 ☐ No		4☐Pregnant at			Other (specify)				Month	Day Year
ords, F.O requires that the leen signed by th hould be detache	O. H.	9 Unknown Part II. Other significal	at conditions o		ut not reculting	o in the ur	adarhing cause and	on in Part I	23e. Did	tobacco u	se contribute to	the cause of death?
ires the signed at be d	ř	1. 5		atia	at not resulting	j ili tilo ul	identying cause give	minit alli.				bably 4 Unknown
requipelent shoult	1				*:				24a. Wa	s an	24b. Were aut	opsy findings available
e la has	1000								aut	opsy formed? 200 No	prior to condeath?	opsy findings available ompletion of cause of
VICIAN: The sician: The certificate rector, pag		25. Was case referred	to medical					26. Place of De	ath (Check only		10,163	20.10
OI VITA Physician: rthis certific ral director,	0	1 TYes 2 No		Hospital: 1 ☐ Inpatie	ent 2 ER/	Outpatien		4   Nursing	Home 55 He			ify)
			5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury	Work		28d. Describe	how injur	y occurred	
INISION  for Attending after death.  Director: After In by the fune	1	2 Accident 3 Suicide	investigation Could not be		usy - At home	form etre	M 1 ☐ `	Yes 2 □ No	28f. Location	(Street and	d Number or Ru	ra I Route Number,
l or Attendeatt of the Director:	1	27. Magner of Death 1 Palatural 2 Accident 3 Suicide 4 Homicide	determined	building, et	c. (Specify)	iaini, sti	eet, ractory, onice		City or T	own, State	)	,
DIVI Hospitel or At 24 hours after d Funerel Direct etely filled in by		29a. Certifier		ysicien: To the best niner: On the basis of and manner st	f examination :							
To the Hos within 24 h To the Fur		29b. Signature and title	e of certifier	2.13			29c. License	number		29d. Dat	e signed (Month	, Day, Year)
20%		focs	y Juan	F-03	4		1 228	5257	(mD)	71	13/06	
307		30. Name and address	Stranson who	and of	Jeath (Item 23a	a) (Type,	astal	Herry	O caan	~ C	ty mi	21842
	State	31. Date filed (Month,	Day, Year)	32. Registi	ar's Signature		2			(	J	
Regis	stra	A	PR 142	2006	on H	A	mille					

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Evelyn B. Shulman 6:08 A. M ĪÖ. April 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2√F New York Director 100-03-9533 95 1910 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County r 28a-f show 10d. Inside City Limits Director Maryland Montgomery 1√2 Yes 2 □ No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or 3701 International Drive, # 217 20906 U. S. A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Homemaker Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Bronstein Celia Rabinowitz ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Hilde M. Alter - Daughter 14116 Bauer Drive, Rockville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Department of Important: If any Injury or once. Garden of Remembrance 4-12-2006 Clarksburg, Maryland 21. Signature of Funeral Service Licens Edward Sagel Funeral Direction, Inc. Donald ( 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Pneumonia Priset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown s been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 24 No Completed 1 TYes 3 ☐ Probably 4 ☐ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes X ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 📉 No 1 🔀 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No the Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D18726 April 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Dr. Arthur Schoengold 18111 Prince Philip Drive, Olney, Maryland 31. Date filed (Month, Day, Year) State 2006 Registrar

### 06-02666 Elisabeth Stanford

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	F	1- For State Crivial yland / Department of Fleath and Weiling Registrar Certificate of Death		eg. No. 200	5_131.86
Physician Medical Examine		1. Decedent's Name (First, Middle,Last) Elisabeth Christian Stanford	2. Date of Dea Month April 19, 2		3. Time of Death 1615 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of 4960 Wyaconda Road - track #2  Rockville		4c. County of Dea Montgomery	h
Funeral	٩	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. B	rthplace (State or Foreign
Director		220-27-9946 1 Months Days Hours	March	15, 1990 ^C	ountry) Maryland
any	-	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County           10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.		Maryland Montgomery Silver Spring			1 Yes 2 X No
the Maryla a or 28a-f		10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	intry?
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  or other traumatic event, the Medical Examiner must be notified at once.		10110 Tenbrook Drive 20901  11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig	in? ( Specify Yes or No	USA 14. Race - Ame	rican Indian, Black,
death or item	runerai	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	White, etc.	hite
rs after ural", miner	함.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give	cind of work done	Specify:	
72 hou n "nate al Exa	ered -	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT			·
within jeer tha	Completed	11 Student		Educati	on 
21215-0036 Uld be filed within 7 Mental Hygiene c event, the Medica	200		s Name (First, Middle, ryl A. Haut	,	
21, hould b ad Men is mar		19a. Informant's Name/Relationship (Type, Print) Sheryl A. Haube/ Mother  19b. Mailing Address (Street and Num Sheryl A. Haube/ Mother 10110 Tenbrook Dr:	ber or Rural Route Nu	mber, City or Town, Stat	
and 2 sho ealth and traumat	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	April 21	1	
nore		1 Burial 2 x Cremation 3 Removal from State crematory or other place) Metropolitan Crematory	2006	<b>'</b>	a, Virginia
Baltimore, MD 21215-0036  Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	4   Donation 5   Other Specify   21. Signature of Funeral Service Licensee   22. Name and Address of Eachity   1. The Country of Funeral Service Licensee   22. Name and Address of Eachity   23. Name and Address of Eachity   24. Name and Address of Eachity   25. Name and Address of Eachity   25. Name and Address of Eachity   25. Name and Address of Eachity   25. Name and Address of Eachity   25. Name and Address of Eachity   25. Name and Address of Eachity   25. Name and Address of Eachity   25. Name and Address of Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity   25. Name and Eachity	lins Funera	l Home Inc	
V	4	23a. Part I. Enter In. disease, or complications that caused the death. Do not enter the mode of dying, such as co	Blvd, W, S	Silver Spri	ng, MD 20901 Approximate Interval
Physician /Medical	1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple injuries	, a	and all and all thouse	Between Onset and Death
Examiner	1	or condition resulting in death)  Due to (or as a consequence of):			
	<u> </u>	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
760, frate be executed physician and the burial - transit	ŭ ŭ	d.	loc m		
760, icate be exphysician the burial	Medical	XX AMENDED iten#23a,27,28a-f,perME,g855,5/1/ iten#28f,perME,g855,5/18/06 TT		1	
5876 ertificat fing ph		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d. Date of delive Month	ry Day Year
Box 68's e death certiff the attending ed for use as the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the stren	ysician	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown			
O. E	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa		obacco use contribute to	
IS, P quires then signed and be defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defined by the defi				s 2 No 3 Pro	
cord law rec has bee	Completed	·	24a. Was autop perfo		utopsy findings available completion of cause of
TRe	6	25. Was case referred to medical 26.Place of Death		2_No 1 🗸 Y	es 2 No
F Vita Physician or this cer ral direct	ן מֿ	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	Nursing Home 5	Residence 6 Other	er: Scene
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the all Directors. After this certificate has been signed by led in by the funeral director, page 2 should be detach		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  April 19, 2006 4:00 P.M. 1 Yes 2x	nerself:	how injury occurred St in the path of	bject placed
risio		2 Accident Investigation 28e, Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Div	Certification:	4 Homicide determined (Specify) Train tracks	Track # 2	Rockville,	ural Route Nymber, City nda Road MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of certification and produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produced for the produc	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate one)		, ,	
To vii	≨ŀ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Me	onth, Day, Year)
		AIBLE IN O.C.M.E.		April 20, 2006	
		30. Name and address of person who complèted cause of death (Item 23á)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Stat		31. Date filed (Month, Day, Year) 32. Egistrar's Signatu			
Registra	ar_	APR 2 4 2005			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ada Marie Suit April 12, 2006 1:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Yrs. Director 578-40-0815 95 Feb. 5, Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23s or 28s-1 show any injury or other treumatic avent, the Madical Exam set must be multiped at angles. Once. 10c, City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Calvert County Forestville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3111 Newkirk Ave. U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þχ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerical/Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Virginia Stinnett Favette Fowler 19a. Informant's Name/Relationship (Type, Crint)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3375 Hall Creek Lane, Owings, Maryland 20736, ce of Disposition (Name of Interpretation of Computery, crematory or other place)

Owings, Maryland 20736, Date 2006. Location - City or Town, State 2006. Jacqueline S. Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery April 15. 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Fundamental Manager Part 1 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Obstructive Airway disease Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the a 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hyponatremia, Hypertensive Heart disease 1 Yes 2 No 3 Probably 4 Unknown should t Completed Cor- Pulmonale, Renal insubsiciency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t rector, page 2 s autopsy performed Dementia. 1 ☐ Yes 2 ☐ No 2 No Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this After the funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Aft
d in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined n 24 hours after der na Funeret Directo bletely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) -ona; D 50653 4-12-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN - C . SURANA D church ton Deale Road Deale MD 31. Date filed (Month, Day Year) 32. Registras Signature State 1 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🖺 🦒 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1411 2006 10 Arthur James Tindley Poril 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HICOMICO KNAKANA REGIONAL MEDILOSE SAISB419 16NTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hous Min. (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Months 11XM 2□ F Yrs. MD Nov 4, 1912 217-14-8527 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 TXYes 2 □ No Worcester Newark MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21841 U.S.A. 8528 Tindley Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Painter Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Waffy Selby Arthur E. Tindley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7547 Acorn Rd., Newark, MD 21841 of Disposition (Name of Date 20c. Lo Viola Hunter/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Williams AME Cemetery 4/15/2006 21. Signature of Funeral Service Liceosee 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 36 hauss 512 Due to (or as a consequence of): : latera S- quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) tonte Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Mellita inbetec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 100 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Hipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Ceath 1 tural

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ဂ္

**Funeral** 

Director

worle

nem 27 ie marked other then "naturel", or items 23s or 28s-f ehoi other treumstic event, its Medical Examinal must be notified at

permit. Peges 1 and 2 should be filed withir Depentment of Heath and Mentel Hygiene. Important: if item 27 is marked other then eny injury or other trainmain.

-14-852

217

5-0036

Maryland 2121

Baltimore,

Box 68760

P.O.

Division of Vital Records,

icien and burial-transit ettending physicien for use as the burial After this certification funeral director, I

Physician/Medical

29a. Certifier (Check only one)

The law requires that the deeth certificate be executed or Attending Physicien: s etter death. within 24 hours efter death To the Funerel Director: / completely filled in by the f

State

Be Completed by Medical Certification: To

5 Pending 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

investigation

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier 1. ale

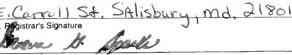
00041211

29d. Date signed (Month, Day, Year) 4-10-06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St. ternando Hele 32. Pigistrar's Signature

31. Date filed (Month, Day, Year) APR 1 4 2006



DHMH 17 Rev 1/2001

Registrar

			•			of Health and M	•	and the area and	13489
		1 _ State	olate of Mary			of Death		Reg. No.	10407
		Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
Physicia /Medic	8	Grace Lorrai	ne Tho	omas			APRIL	17 2006	
Examin	475	4a. Facility Name (If not institution, give st	reet and number)		4b. City, 1	own, or Location of Death		4c. County of De	eath
		St. Mary's Hospit	al			Leonardtown			Mary's
Funeral		5. Social Security Number 6. Sex	M 2KIE	rrs. last birthda; Yrs.		Year If Under 24 Hrs. Days Hours Min.	8 Date of Birt (Month, Da	y, Year)	lirthplace (State or Foreign Country)
Director		Usual Residence of Decedent	77	7 Trs.			8/12/19	928   Ti	nicum, PA
yland		10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
Mar-f st	tor	Maryland St. Mary	''s		Tall	Timbers			1 ☐ Yes 2X No
n the	lre	10e. Street and Number			10f. Zip	Code		10g. Citizen of What	Country?
atior death with the Marylan or Items 23a or 28a-f show oringt must be notified at	Funeral Director	17881 St. George'	s Park Road	1		20690		USA	
ems erm	Iner	11. Marital Status	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	n U.S. 13	<ol> <li>Was Deceded</li> <li>If Yes, spec</li> </ol>	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Ar Black, W	nerican Indian, hite, etc.
or It	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 ☐ MNo If Yes, Give		1 ☐ Yes 2	XNo Specify:		Specify:	White
n 72 hours "natural", edical Exe	q p	3 Widowed 4 Divorced	Year or Dates:	162 Doc	cedent's Usua	Occupation		16b. Kind of Busine	es/Industry
"nat	ete	15. Decedent's Educ (Specify only highest grade	completed)	(Giv	ve kind of wor DO NOT us	done during most of work retired)	ing	West Ches	•
12 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Ite Medical Examinal must be rediffed at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4		Teach				ol District
filed Hygi ther ant, I	S	17. Father's Name (First, Middle, Last)		IRCH	reach		e (First, Middle,	Maiden Sumame)	or process
0 = 0 >	o Be	Hiram Beer				Rehe	Dheil		
should be ind Mental ind marked c	ြ	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Ma	iling Address	Street and Number or Run			, Zip Code)
and 2 sealth ar n 27 is		Lois Thomas Stove	r / Daughte	er 1788	1 St. (	George's Parl	c Rd 1	Tall Timbe	rs. MD 20690
Hea Hea tem othe		20a. Method of Disposition		b. Place of Dis		e of	Date	20c. Location - City	
Pages nent of int: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Re  1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	irmingh			/2006	West Ches	ter. PA
artme ortan injur		21. Signature of Funeral Service Cicense				Address of Facility Br			
permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 Is marked any injury or other traumatic e ones.		Edward N. Brinsfiel	d. Jr. MOO						MD 20650-0279
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one							Approximate Interval Between
Physician		Immediate Cause (Final	D.						Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a con	sequence of):					lady
Examiner			,	, ,					
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):					
outed	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
be executed sician and burial-transit		resulting in death) Last	Due to (or as a con	sequence of):					
te be ex nysician ne buria	cal	d.							
leath certificate attending phys	Physician/Medio	IF FEMALE:							
th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	Fetal death	3 □Ectopic pre			23d. Date of Month	delivery Day Year
ed fo	sici	1 ☐ Yes 2 ☑ No	4☐Pregnant at time 9☐Unknown	of death 5	5 ☐ Other (spe	icify)		, worth	ouy
at the de	Phy	9 Unknown				in Bad I	230 Did t	obacco use contribute	to the cause of death?
w requires that been signed E should be deta	þ	Part II. Other significant conditions cont	ements	. resulting in the	andenying ca	use given in Part I.		_	Probably 4 Unknown
een s	ted	H ( Crostneys )	emenia					1	
elaw hasb je2st	Completed	· · · · · · · · · · · · · · · · · · ·					24a. Was autor	osv prior	autopsy findings available completion of cause of
ysician: The is certificate his director, page	Con						1 ☐ Yes	med? death	es 2 No
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	- Ball			26. Place of Deat	th (Check only o	one)	
Physic this c	2	T Yes 2UNO		2 ER/Outpat				dence 6 Other (S	pecify)
ing F	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	(r) 28b. Time	y M	Bc. Injury at Work?	28d. Describe	how injury occurred	
tend leath tor; /	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Office of leiver	At home form		1 Yes 2 No	29f Location /	Street and Number or	Rural Route Number
or Al ifter of Direction by	III	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp		street, ractory	office	City or To	wn, State)	noi ai noute i vuilibei,
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director; After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Ce	29a. Certifier 1 Certifying Phys	ician: To the heat of my	knowledge de	ath occurred	at the time, date and place,	and due to the	cause(s) and manner	as stated
Hos 24 ho Fun	Medical					in my opinion, death occur			
thin the	Me	29b. Signature and title of certifier	and marinor states.		29c	License number		29d. Date signed /M	onth, Day, Year)
F 3 F 8		D. 1	llexand	e A	AD	D52815		4/17/0	
		30. Name and address of person who con	moleted cause of death	(Item 23a) /Tim		3		1 , 1	
		DANIEL ALEXANDER	PO BOX 527			OSPITAL LEON	ARDTOWN	MD 20650	
Sta	te	31. Date filed (Month, Day 18") 2006			- Min				
Registr		APR 1 6 2006	Joseph .	S A					

Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, GRACE LORRAINE THOMAS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Physician April 20, 2006 4:30 a.m. Frank Turner, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown II Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**8**M 2□F Hours Months Days Yrs. May 8, 1925 Director 80 229-28-7336 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a Stale ehow item 27 is marked other then "neturel", or items 23a or 28a-f ebox other traumatic event, the Medical Examinan must be mailled at 1 ☐ Yes 2 X No Director Maryland St Mary's Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45772 Nancy Lane 20634 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aviation Mechanic U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be marked o 2 Frank Turner, Sr. Maud Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Evelyn Turner / Wife 45772 Nancy Lane, Great Mills, Maryland 20634 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gdns 4-27-2006 Waldorf, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee any r Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on easy ne. Do nymeter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Of et and leath Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-translt Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, oulcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day ğ Month Year 4☐Pregnant at time ol death 5 Other (specify) P.O. ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an page 2 2 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/OutpatienI 3 DOA this 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 27. Manner ol Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 Suicide 28e. Place ol Injury - Al home, farm, street, lactory, office building, elc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or to the Funeral Directompletely filled in by 4 Homicide Hospital or 29a. Certifier 🙋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mayner stated. (Check only one) To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mes use of death (Item 23a) (Type, Print) person who completed Ρ. Patrick, M.D 24035 Three Notch Road, Hollywood, Maryland 20636 James 31. Date filed (Mont . Registrar's Signature State 1 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Physician /Medical Examiner

VERNON, GEANNE

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar		Cei	rtificate of D		Reg.	7000	13491
an	Decedent's Name (First, Middle, L  Jeanne M		on			2. Date of Death Momh	Day Year	3. Time of Death
cal ier	4a. Facility Name (If not institution, g		011	4b. City, Town, or L	ocation of Death	HPNIL	4c. County of De	06 1432 M
IGI	PENINSULA REGIONAL	Medicas C	Centrel	50/1	shing			omico
	5. Social Security Number 6. 221–16–1779  Usual Residence of Decedent	1 DAL OFFI	(In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye)	9. B	irthplace (State or Foreign Delaware
	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
tor	Maryland Talbo	t	Easton					¥☐Yes 2☐No
)Ire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	Country?
ral	8910 High Banks			21601			USA	
une	11. Marital Status	12. Was Decedent E Armed Forces?	l l	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite. etc.
Completed by Funeral Director	1 Never Married 2 Amarried 3 Widowed 4 Divorced	1 ☐ Yes 2 ZXNo If Yes, Give Year or Dates:		I□Yes <b>X</b> □No	Specify:			hite
ete	15. Decedent's E (Specify only highest g		16a. Deced	lent's Usual Occupation kind of work done dur OO NOT use retired)	on ring most of workir	16b	. Kind of Business	s/Industry
dwc	Elementary/Secondary (0-12)	College (1-4or 5+	Teach				Education	on
BeC	17. Father's Name (First, Middle, Las			11	8. Mother's Name	(First, Middle, Maid		
10 B	William Monteit	n			Mary Co			
	19a. Informant's Name/Relationship			g Address (Street and				Zip Code)
	Jeff Vernon/hush	oand		7 Mallard			1875	
	20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 [			natory or other place)			Location - City or	
	4 □Donation 5 □ Other (Special Signature of Funeral Service Lice			y Cremator			alisbury	
	wall Hol	76		HÖlloway F	uneral H	ome Profe	ssional	Association 804
	23a. Part. Enter the disease, or con- enock, or heart failure. List only	nplications that caused to	he death. Do not ente	or the mode of dying,	such as cardiac or	respiratory arrest,	אין אין	Approximate
	Immediate Cause (Final disease or condition	one cause on each line	100 0 0		6.1	1		Interval Between Onset and Death
	resulting in death)	a. Due to (or as a	consequence of):	u e	muo	us		< luk
_	Sequentially list conditions,	DV	T					<) week
lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					1 3
хал	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					Luxel
2	(	d						
medical Examiner	received.							
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		Ectopic pregnancy			23d. Date of de	livery
Completed by Physician	in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown		Other (specify)			Month	Day Year
	Part II. Other significant conditions		not resulting in the use	derlying cause gives :	n Part I	22a Did tobs	Numa nontribut	- h
2	Chronic	61	pain	oenying cause given i	II Fail I.	1 Tes		the cause of death?
2010	Openia		frain !			-		
5	MICITIA					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
2	25. Was case referred to medical			26	3. Place of Death	1 Yes 2		2 □ No
2	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatient	Othor		9 5 ☐ Residence	6 □Other /Soa	cuba)
5	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Oate of Injury (Month, Day Y	28b. Time of	28c. Injury at Work?		d. Describe how in		CH <b>y</b> )
5	2 Accident investigatio	-		M 1 ☐ Yes	2 No			
	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, stree (Specify)	et, factory, office	28	f. Location (Street a City or Town, Sta	and Number or Ru te)	ıral Route Number,
ואפעונמו כפוווונימווסוו, וס	29a. Certifier 1 Certifying Pt	hysician: To the best of	mu kaandadaa dank					
	(Check only 2 Medical Examone)	hysicien: To the best of r miner: On the basis of ex and manner state	tamination and/or inve	estigation, in my opinion	date and place, an on, death occurred	d due to the cause( I at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
Ě	29b. Signature and title of certifier			29c. License nu	ımber	29d. D	ate signed (Monti	h, Day, Year)
	Kime	2160		1101	11.17	77	21/10	1/5/
	30. Name and address of person who	completed cause of deal	th (Item 23a) (Type, P	rint)			7/16	100
	ELLEDA ZIEME		E. CAMPOUS	T. SAlish	uny, Ma	1.21801		
	31. Date fled (Mohith, Day, Year) APR 1 4 2	2006 32. Progistrar's	Signature	- 00 -	, ,			
1		A MELAN	s Kr Kg	J.C.J		-		

DHMH 17 Rev 1/20

Sta Registr

			1 - For State Registrar	State of Ma			rtment of Hetificate of L			_	giene Reg. No.	006	13492
			1. Decedent's Name (First, Middle, Las	t)						2. Date of De			3. Time of Death
	Physici		Passii A	Vial						Month	Day		0615AM
1/4	/Medi		4a. Facility Name (If not institution, give	otroot and number)			4h Cihi Taua aa	Location	- of Dooth	4	11	County of Death	
1	Examir	er	0 1 1 11	11 . 1) 1		j	4b. City, Town, or	Location	n of Death		1 .		A .
			Coastal Hoppice At	The Lake			Dalesby	my				Dicomi	
	Funeral		5. Social Security Number 6. Se	x 7.Aga ⊒M 2⊡MF	e (In yrs. last birt		If Under 1 Year Months Days	Hours	Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth	place (State or Foreign ntry)
	Director		210-48-6164		_59	Yrs.			1	May 9,	1946	]	DÉ
	2 2		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	2 05 1 05	ention						404 114. 02. 11. 2
	aryla	-	,										10d. Inside City Limits
	9 P	Director	MD Worcest	er	Bishop	Vil	.te						1⊈Yes 2 No
	5 th	ire	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Cou	ntry?
	17 w		9516 Morris Rd.				21813					U	SA
	dea Fins	Funeral	11. Marital Status	12. Was Decedent I	ver in U.S.	13. W	as Decedent of His	spanic C	rigin? (Sp	ecify Yes or No	-	14. Race - Amen	can Indian,
9	after or the		1 Never Married 2 Married	Armed Forces?	lo		Yes, specify Cubar			Hican, etc.)		Black, White	
ဗ္ဗ	within 72 hours after death with the Maryland she. than "natural", or items 23a or 28s-1 ahow ia Madisal Examinar must be notified at	þ	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 No	Specify	y:			Specify: Bla	ack
9	2 ho	Completed	15. Decedent's Ed		16a.		ent's Usual Occupa				16b. Kir	nd of Business/Ir	ndustry
21215-0036	r c	pie	(Specify only highest grad			life. D	ind of work done du O NOT use retired)	uring mo	ost of work	ing			
7	the ign	E	10th	College (1-4or 5	+)		none					none	
O	Hyg the		17. Father's Name (First, Middle, Last)					18. Moti	her's Name	e (First, Middle,	Maiden		
Maryland	d be ental	o Be	George H. Rayne, S	r				<b>C1</b>	00 DT	444		,	
2	d Me d Me mark mati	ဥ	19a. Informant's Name/Relationship (T		106	Maida	Add (011		eo PI		0.11	<b>—</b> • • • •	
Ma	12 s h an 7 ts i			ype, Friin)			Address (Street ar				-		code)
ď.	and leelt m 2		Cleo Rayne/mother				Morris Ro	1.,					
0	of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ I	Removal from State	cemeter)	v, crem	ition (Name of atory or other place	)		Date	20c. Lo	cation - City or T	own, State
Ē	Pag ment mr; ury		4 □ Donation 5 □ Other (Specify,		Curtis	UM	C Cemeter	У	4/15	/2006	Bis	hopville	e, MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow apprintly or other treumatic avant, it a Medical Examinar must be notified at ance.	2 "	21. Signature of Funeral Service Licens	600			Name and Address						
m	89 E E 8		Talasablu	ilson		Le	wis N. Wa	tson	n Fun	eral Ho	me	1001	
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do n	ot ente	r the mode of dying	, such a	s cardiac	or respiratory ar	rest.	1001	Approximate
-			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	9.				-				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Illeta	STETIL		Breat		Co	near			
	Examiner			Due to (or as a	a consequence o	of):							
		-	Sequentially list conditions,	b	e de principal de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia de la Colonia d	*				,			
	sit ad	ine	if any, reading to immediate cause. Enter Underlying	Due to (or as a	s consequence o	ety;							
	ecut and tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
Ö	e ex	Ē	in a south, and	Due to (or as a	a consequence o	it);						1	
8760,	cate be executed physicien and the buriel-transit	dicai		d									
<u></u>		Jed	IS SEMANE										
Вох	endii use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		2 🗀					2	3d. Date of deliv	ery
Ω.	deat d for	Cia	in the past 12-pronths?	1∐Live birth 4∐Pregnant at			ctopic pregnancy Other (specify)					Month	Day Year
o.	that the death certified by the attending detached for use ea	Physician/Me	9 □ Unknown	9Ll Unknown									
ם ַ	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use es	d l	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the und	derlying cause giver	n in Part	1.	23e. Did to	obacco us	se contribute to t	he cause of death?
g	w requires to been signer should be	d by					, ,			101	As 2	No 3□ Prot	pably 4 □Unknown
Ö	v requ been shoulk	Completed									- 7	J.10 0	
ec	hast pe2s	횰								24a. Was autop		24b. Were auto	psy findings available mpletion of cause of
_	The ate page	ဉ် ကြ								perfor	med?	death? 1 ☐ Yes	20 No
<u> </u>	Physician: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				:	26. Plac	e of Death	Check only o			
2	Physic this ce al dire	To!	1 □ Yes SINo	lospital: Inpatier	nt 2 ER/Out	patient	3 DOA Other	: 4□N	ursina Ho	me 5 ☐ Resid	lence 6	Other (Special	(v)
0	erth eral		27. Manner of Death	28a. Late of Injur	y 28b. Ti		28c. Injury a Work?			28d. Describe h			,,
Division of Vital Records,	ding th. : After s funer	윤	Natural 5 Pending investigation	(Month, Day	Year) In	jury		, es 2 [	]No				
18	l or Attending after death, Diractor: Afte in by the fune	100	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	rv - At home, far	m. stree	at factory office			28f. Location (S	Street and	l Number or Rur	al Route Number,
á	lor A after Dirac	Certification:	4 Homicide	building, etc	. (Specify)		, , , , , , , , , , , , , , , , , , , ,			City or Tow			
	ours ours illec		29a. Certifier Certifying Phy	Rician: To the best o	f my knowlodgo	dooth							
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exami	sicien: To the best oner: On the basis of	examination and	Vor inve	estigation, in my opin	, uate a nion, de	ath occurr	and due to the o ed at the time, o	date and	and manner as s place, and due t	tated. o the cause(s)
	mple mple	Me	29b. Signature and title of certifier	and manner stat	)		29c. License i						
	5 3 E 3	\$	200. Ognature and title of certifier	0/8/	an				~ ~			signed (Month,	
	(DI)		INU (	( y	M		Do	16	21	0	7-	11-06	
	100	p (	30. Name and address of person who co	ompleted care of de	ath (Item 23a) (1	Гуре, Р	,						. ===
_	<b>V</b>		Hourd Coverell, NO C	sestel Hosp	me po	C	Ox 1733	3	Soul	sh n	ND	2180	72
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature		_			0			
	Registr	ar	APR 1 4 20	106   180900	2 B	Polon	all 1			_			
		_			-	-			-				

State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 8, Day 2006 Year Earle L. Valenstein 11:27 am /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5737 Bar Neck Rd. Cambridge Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ 2□ F Days Yrs. Director 213-12-4051 83 1923 10. Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Medical Evantrat must be nytitled at Directo Maryland 1 ☐ Yes 2 ☐ No Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5737 Bar Neck Rd. 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueric Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Item eny injury or other treumatic event, it will be a page. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Army Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martin M. Valenstein Gertrude E. Levine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Banghart Valenstein/Spouse 5737 Bar Neck Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) ArlingtonNationalCemetery 6/2/2006 Arlington, VA Curran-Bronnwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 Signature of Funeral Service Licensee desentitionas 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart delitre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 3 Weeks /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rertens Due to (or as a consequence of): attending physician and for use as the burial-transit law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. м 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D47492 10/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey T. Denton, M.D., 555 Cynwood Drive, Easton, MD 21601 31. Date filed (Month, Day, Year) Blan & April Registrar

			1 - For State Registrar		State of	Marylar		artmen rtificat			and M		Reg. No.	06	134	94	
2 23	Physici	an	Decedent's Name (First, Middle	e, Last)								2. Date of De Month	aath Day	Year	3. Time of		
	/Medio	cal	WILLIAM HENRY  4a. Facility Name (If not institution					4. 65	-		<b>15</b> #	APRIL	11	2006	4:00	P ^M	
	Examir	er	,	. 3	eet and numb	er)			ESTE	Location of	or Death			inty of Death	TR I C		
	Funeral	-34	505 BLENNY LAN 5. Social Security Number	6. Sex	7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bir	QUEEN ANNE S  Birth Day, Year)  9. Birthplace (State or Foreign Country)				
	Director		577-46-4369	1 🗶 A	1 2 F	68	Yrs.	Months	Days	Hours	Min.	NOV. 2	ay, Year) <b>9. 193</b>	7 DC	ntry)		
	pu ,		Usual Residence of Decedent			100 0	ty, Town or Lo								0.1 1 0.2		
	ehov	ក	10a. State 10b. County		nla			cation							0d. Inside Cit 1 ☐ Yes	_	
	the Marylar 28e-f ehow	Director	MD QUEEN  10e. Street and Number	ANN	F. 2	СН	ESTER	10f. Zip	Code				10a Citizen	of What Cour			
	with Sa or	ă	505 BLENNY LAN	TC .					619				USA	or writer cour			
	within 72 hours effer death with the Maryland ene. than "natural", or iteme 23s or 28e-f ehow the Mucical Exercities must be notified at	Funeral	11. Marital Status		. Was Decede	ent Ever in U	l.S. 13.			spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		Race - Americ			
9	or Ite		1 ☐ Never Married 2 Mar.	ried	Armed Force			If Yes, spec 1 ☐ Yes				Hican, etc.)		Black, White, oc <i>ity:</i> WHI			
21215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced		If Yes, Give Year or Date	es:		10165	ZIALINO	эрөспу.			Spe	icity: WILL	. I.E		
<u>7</u>	"natu	Completed	15. Deceden (Specify only highe	t's Educa st grade d	tion completed)		16a. Dece	dent's Usua kind of wo DO NOT us	de dona d	lucina most	t of work	ing	16b. Kind o	f Business/In	dustry		
7	withir Bne. than	dmo	Elementary/Secondary (0·12)		College (1-4	or 5+)		MIST	se генгеа)	,			II C	GOVERN	мгит		
	filed Hygi other	e C	17. Father's Name (First, Middle,	Last)	<u></u>		CIII	ELLUI		18. Mothe	r's Name	(First, Middle			IIIII I		
Maryland	Alental rked o	To Be	WILLIAM HENRY	WEBS'	TER, SI	R.				ETH	EL E	INNIX					
ary	iges 1 and 2 should be filed within 72 hours efter death with the Maryla nt of Health and Mental Hyglene.  If Item 27 Is marked other than "natural", or Iteme 23a or 28e-f ehov or other traumatic event, the Madical Experiment percelling and		19a. Informant's Name/Relations	hip <i>(Type</i>	, Print)		19b. Maili	ng Address	(Street a	nd Numbe	or or Rura	al Route Numb	er, City or To	wn, State, Zip	Code)		
	and and mark		JUDITH MARY WE	BSTE	R/WIFE	1				NE, C		ER, MD	21619				
O.	Pages 1 nent of H int: If Ite iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation	3 □Rer	noval from Sta	200. F	Place of Disponentery, creek ESAPEAK	natory or o	ne ot ther place ΜΔΤΤ	ON		Date	20c. Locati	on - City or To	wn, State		
altimore,	t. Partmen		4 Donation 5 Other (S				TER, I	LC.		0		/2006	STEVI	ENSVILI	E, MD		
Ba	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service	Licensee	100		F	2. Name an ELLOW 06 SH	S. H	ELFEN	BEIN	& NEWN	NAM FUI R, MD	TERAL 1 21619	IOME, E	.A.	
760,	Physician /Medical Examiner  the private transit	cal Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c. d.	Due to (or	as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a c	pal quence of):	N CV EC					11631,		Approximate Interval Between Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Cons	ween Death	
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□ Pregnan 9□ Unknow	n 2∏Feta it at time of d n	al déath 3 [ death 5 [	Ectopic pr Other (sp	ecify)				23d.	Date of delive	,	/ear	
	quires than a signed ald be de	þ	Part II. Other significant condition	ons contri	buting to deat	h but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did t	obacco use o		ne cause of de ably 4 □U		
Division of Vital Records,	The ate h	Completed							-			24a. Was autor perfo 1 - Yes	an 24 psy prmed? 212 No	death?	psy findings a mpletion of ca 2 \( \text{No} \)	available ause of	
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	_	spital:				Othe			(Check only o		-			
ion of	ding Phy h. After this funeral d	atlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendir 2 Accident investi		28a. Date of (Month,		ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 🗆 140		me 5 Resi 28d. Describe			/)		
Divis	- 9	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place of building	Injury - At h , etc. <i>(Specil</i>	ome, farm, str	eet, factory	, office			28f. Location ( City or To		imber or Rura	l Route Numb	ber,	
	To the Hospitel or A within 24 hours after of To the Funerel Directompletely filled in by	edical (	29a. Certifier 18 Certifyir (Cneck only one) 18 Certifyir 2 Medical	g Physic Examine	ian: To the be r: On the basi and manne	s of examina	owiedge, deat ation and/or in	n occurred vestigation.	at the time in my op	e, date an inion, deal	d place, th occurr	and due to the ed at the time,	cause(s) and date and place	manner as si ce, and due to	ated. the cause(s)		
	To th Within To th	Me	29b. Signature and title of certifie		ich (	10		290	License		20			ned (Month,			
•			, , , ,						01	-18	78	American Services	4	11-06			
	OKK		30. Name and address of person Stvavt E.	sei	onicu	i, mi	) (	90C		esta	ate	Rd.	Anna	polis	, Mid	1.	
33.8	Sta Registr		31. Date filed (Month, Day Year)	13	32. Reg	is ar's Signa	ature #	Good	EL P								

			1 - For State Registrar	State of Maryla		rtment of H			piene 06	13495
	Physic /Med Exami Funeral	cal ner		Mae Fe ye street and number)  Y Care Cev Sex 7. Age (In yrs	s. last birthday)	4b. City, Town, or	Location of Dea	2. Date of Deal Month  The control of Birth	th Day Year 10, 2006 4c. County of Deat DOYCH	h
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. This marked other then "natural, or Itams 23e or 28e-1 show any injury or other treumetic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10e. Street and Number  2 4 3 Roll  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest grave)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last, Roll  19a. Informant's Name/Relationship (	Dy V  12. Was Decadent Ever in Amad Forces? 1 Yes 2 DNo If Yes, Give Year or Dates:  ducation ade completed)  College (1-4or 5+)  Type, Print)  Fergus on 20b.  Removal from State (y)	16a. Decede (Give hi life. Do.)  Prod  19b Mailing  440  Place of Disposit cometery, crema	ation    DY   GG   10f. Zip Code   2   2   3   3   3   3   3   3   3   3	spanic Origin? (s , Mexican, Puer Specify: tion uring most of wo 18. Mother's Nai Lu- and Number or Ri Lu- and Number or Ri Lu- and Number or Ri Lu- and Number or Ri Lu- and Number or Ri Lu- Lu- Lu- Lu- Lu- Lu- Lu- Lu- Lu- Lu-	Specify Yes or Noto Rican, etc.)  Trking  Nar Ker  The (First, Middle, Nar Beltway  Date  15/66  (Home, 1	Og. Citizen of What Co  14. Race - Amel Black, White Specify:  16b. Kind of Business/I  Canning Maiden Surname)  B' Shof- City or Town, State, Z.  20c. Location - City or Town, de	ary/and  10d. Inside City Limits  112 Yes 2 No  untry?  A  nican Indian,  a, etc.  a CK  industry  g Factory  procode)  MD 2161  wn/ State  MD.
68760,	hilicate be executed by Scician and Examiner as the burial-fransit	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End 5 t a  Due to (or as a conse	oge requence of): ension quence of):  where here	the mode of dying,	such as cardiad	c or respiratory arre	st,	Approximate Interval Between Onset and Death & Months
P.O. Box	at the death cer by the attendir tached for use	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1	al déath 3 □Ed death 5 □ C	stopic pregnancy ther (specify)			23d. Date of deliv Month	ery Day Year
Vital Records, I	e law requires tha has been signad je 2 should be de	Completed by F	Part II. Other significant conditions or diabetes	ontributing to death but not res	sufting in the unde	orlying cause given	in Part I.	1 ☐ Yes 24a. Was an		bably 4 Unknown
Vital Re		Be	25. Was case referred to medical examiner?	Hospital:		0.1		autopsy perform 1 Yes 2	ed? prior to co death? 1 Yes	empletion of cause of 2□ No
of	ding Phys h. After this funeral di	on; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other:  28c. Injury a Work?	4 Mulsing n	ome 5 Residen 28d. Describe how	nce 6 Other (Specific	ý)
Division	pital or Attending Physicien: ours after death. erel Diractor: After this certifici filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			M 1 ☐ Ye	s 2□No	28f. Location (Stree City or Town,	eet and Number or Rura State)	al Route Number,
	Hospi 14 hou Funer Fely fill	Medical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	ysicien: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death or ation and/or inves	ccurred at the time, tigation, in my opin	date and place, ion, death occur	and due to the cau rred at the time, dat	use(s) and manner as s e and place, and due to	tated. o the cause(s)
	To the within 2 To tha comple	W	29b. Signature and title of certifier	o No		29c. License n	oumber 0597		1. Date signed (Month,	Day, Year)
			30. Name and address of person who c	completed cause of death (Item	n 23a) (Type, Prin	nt)			3	
	Sta Registra		31. Date filed (Month, Day, Year)	2006 32. Registrar's Signa	ature	and I	1	2161		

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death  State Registrar  State of Maryland / Department of Health and Mental Hygiene Certificate of Death	96
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year April 11, 2006 6:3	of Death
	Funeral Director	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  CaiMbridge  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 Under 1 Year  1 Under 24 Hrs.  8. Date of Birth (Month, Day, Year)  9. Birthplace (State County)  Work (Month, Day, Year)  Usual Residence of Decedent	or Foreign
C	with the Maryland e or 28a-f show	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside C	City Limits
3	death with th	Funeral Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  2 10g. Citizen of What Country?  2 11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No.)  14. Bace - American Indian	
5-0036	hours after d urel', or iten il Examinat	by	3 1 Widowed 4 □ Divorced   If Yes, Give   1 □ Yes 2 1 □ No Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specify:   Specif	
21215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show way injury or other treumatic event, the Medical Examinat is ust be rightlied at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry  16c. No NOT use retired  Private Resident's Usual Occupation (Give kind of working life. DO NOT use retired)	
Maryland 2	ould be filed Mental Hyg arked other atic event, l	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	nce
	1 and 2 sho Health and em 27 Is ma ther treums	8	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Fred William Cornish  808 Maes Love Canabir, dee MD. 21	1613
Baltimore,	mit. Pages eartment of ortant: If it injury or o		20a. Method of Disposition  1	D.
ğ	permit. Departi Import. eny inj	100	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximation interval Bet	613 te
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Onset and  Onset and  Onset and	
8760,	cate be executed physician and the burial-transit	ıl Examiner		
.O. Box 687	The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 DMno 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Festal death 3   Ectopic pregnancy 23d. Date of delivery Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day 1   Month Day	Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	leath? Jnknown
		Completed		available ause of
	hysici his ce il direc	ation: To Be	25. Was case referred to medical examiner?  1	
5	oital or Attenors after death	Certification:		ber,
	To the Hospital or Al within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
	- s ⊢ ŏ		Mary and More MD D31766 4-13-06  30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print)	
	Star 'Registra	.e	Mary and the order of the signed (Month, Day, Year)  Mary and Morre MD  30. Name and addr & f person who completed cause of death (Item 23a) (Type, Print)  MARY ANN MORE MD, 300 Dovches tev Ave; Cambridge MD 2/6/3  31. Date filed (Month, Day, Year)  APR 14 2006	3

			1 - For State Registrar	State	of Marylai	•			lealth a Death		lental I		ene () (	16	13497
	Physici	20	1. Decedent's Name (First, Middle,	Last)							2. Date o		Day	Year	3. Time of Death
	/Medic		Eura Preston								Apri1	. 9,	2006		3:58 A M
	Examir	ner	4a. Facility Name (If not institution, Holy Cross Hos	=	umber)		1		r Location o Sprin				4c. County	of Death	r37
	Funeral			S. Sex	7. Age (In yrs.	last birthday)		1 Year		_	8. Date o	f Birth			
	Director		239-12-3784	1 🕱 M 2 🗆 F	89	Yrs.	Months	Days	Hours	Min.	Aug.	6 1	1916	Nort	place (State or Foreign http) th Carolina
	pug 🗼		Usual Residence of Decedent  10a. State 10b. County		10c C	ity. Town or Lo	cation								10d. Inside City Limits
	daryle f •ho	or		Georges		illum	Cation								1  Yes 2 No
	r 28a-	rect	10e. Street and Number	Georges	GII	TTTUIII	10f. Zip	Code				10g	. Citizen of	What Cour	ntry?
	deeth with the Maryland ims 23e or 28e-f ehow r must be notified at	al D	1326 Nicholson	Street			2	0782				Į	Jnited	Stat	tes
	tems tems	Funeral Director	11. Marital Status	Armed F			Was Deced	dent of Hi cify Cuba	ispanic Orig	gin? (Sp i, Puerto	ecify Yes o Rican, etc.	r No-		e - Americ	
50	filed within 72 hours after deeth with the Marylen thy giene. Ithe than "natural", or Items 23e or 28e-f show in, I'm Madical Examinat mast be notified at	by F	1 ☐ Never Married 2 ☑ Marne 3 ☐ Widowed 4 ☐ Divorced	d 1 □Yes If Yes, G Year or i	2 📉 No live Dates:		1 ☐ Yes	2 <b>⊠</b> No	Specify:				Specif	y: B1	lack
9-003p	2 hou		15. Decedent's	Education		16a. Deced	dent's Usua	al Occupa	ation			16	b. Kind of B	usiness/in	dustry
7	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)		) (1-4or 5+)				during most f)	t of work	ing				
7	filed with Hygiene other the		12			Post	al W	orke							Office
yland	ntal Hed ot	o Be	17. Father's Name (First, Middle, La James Williams	ast)					18. Mothe			ddie, Mai	iden Suman	ne)	
	Should nd Me mark matic	۲	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailin	a Address	(Street a				ımber. C	ity or Town,	State. Zin	(Code)
Z	alth ar		Dorothy Mae Wil		wife)						illum				, , , , , , , , , , , , , , , , , , , ,
e e	of Hei		20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3	I □ Damouel from		Place of Dispo	sition (Nar	ne of			Date	+	c. Location -	City or To	own, State
DE L	ment ment tant: tant:		4 □ Donation 5 □ Other (Spe		Ft	Linco			- 1	4/13	-		entwo	-	
galt	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other eny injury or other traumatic event, 2016s.		21. Signatur Huneral Service Li	censee									al Se		
	40204	Н	23a. Part1. Enter the disease, or or	omplications that	caused the dea								sh. D.	C. 2	20012 Approximate
	Physician		Immediate Cause (Final	ny one cause on	each line.				g, 02011 ao		- гоор пато	.,	•		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		rdiopul (or as a consec		Arre	st							
	Examiner		Sequentially list conditions,		rdiovas		)isea	se							
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consec	juence oi).									
	execut n end al-trar	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):		_						-	
0/0	icate be executed physicien end s the burial-transit	edicai I		d.											
90	entifica ing ph	Medi	IF FEMALE:										1		
200	w requires that the death certific been signed by the ettending p should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregn birth 2 ☐ Feta	aldeath 3	Ectopic pr						23d. Da	te of delive	ory Day Year
	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Preg 9□ Unkr	nant at time of one	leath 5∟	Other (sp	ecity)				-			,
Z,	s that ned b	by Pr	Part II. Other significant condition	s contributing to	death but not res	sulting in the ur	nderlying c	ause give	en in Part I.		23e. C	Did tobac	co use cont	ribute to th	ne cause of death?
soros,	equire en sig ould b		Dementia								1	☐ Yes	2 🗆 No	3 🗌 Prob	ably ¥⊠Unknown
ວ	law re les be	Completed										Vas an utopsy	24b.	Were auto	psy findings available
	cete h	Con									ρ	erformed s 2	d?   i	death?	_
VII	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check or				
5	Phys or this oral di	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	Inpatient 2  of Injury	ER/Outpatien 28b. Time of		8c. Injury Work	4   1401				e 6 Oth		()
	inding ath. r: Afte	atlo	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investiga		nth, Day Year)	Injury	м		(? Yes 2 □ N						
2	or Atte	Certification;	3 Suicide 6 Could no 4 Homicide determine	ed 280. Place	e of Injury - At h	ome, farm, stre	et, factory	, office			28f. Location City or	n (Stree	at and Numb	er or Rura	l Route Number,
ב	pital o														
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours afterderally and the conflict of the European Signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the terminer: On the terminer	e best of my kno pasis of examina nner stated.	owledge, death ation and/or inv	occurred estigation,	at the tim in my op	e, date and pinion, deat	d place, and the occurrence	and due to ed at the tir	the caus ne, date	e(s) and ma and place,	inner as st and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			0 1.	290	. License	number			29d.	Date signe	d (Month, i	Day, Year)
			Prute	may ,	Pate	role,	M) I	1D420	0216			Ap	ril 1	0, 20	06
	3		30. Name and address of person wh									1			
		10	Pratma Pathak,		500 For				Silve	r Sp	ring,	MD			
	Sta Registr	ar	31. Date filed (Month, Day, Year)	2006	ogistrar's Signa	B A		,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL Year **Physician** 1600 Webb Frances 12,2006 Marie /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner SANDY SPRING MONTGOMERY BROOKE GROUF REHABILITATION AND NURSING CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 200 F 5/06/1924 Wash., D.C. Director 229-18-5904 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location
Sandy Spring 10a. State ob. County Montgomery 1 TYPS AND NO Director 10c. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20860 18201 Slade School Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0020 Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Columbia Gas Secretary 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara V.Middledorf Francis Gill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 882 19a. Informant's Name/Relationship (Type, Print) 23631 Rolling fork Way Gaithersburg, Md Kim Garrison/GrandDaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Culpeper National Cem 4/17/06 Culpeper, Va. 9 4 ☐ Donation # 5 ☐ Other (Specify) 21. Signature of Funeral Service License PHILIP AD RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CAPLINOMA OF THE WING WITH METASTASES Examiner Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ALZHEIMER'S DISEASE þ 24b. Were autopsy findings available prior to completion of cause of death? has been sig ge 2 should b 24a. Was an autopsy Completed performed? ır this certificate haş eral director, page 2 1 □ Yes 2 □ No 1 ☐ Yes 2 2 No To the Hospital or Attending Physician: within 24 hours efter death.
To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 12, 2006 -ATTENDING PHYSICIAN 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 10 M-D, 18100 SLADE SCHOOL KOAD

BROOKE HAFMAN

32. egistrar's Signature,

State Registrar

31. Date filed (Month

		1 - For State Registrar	State of Mary	-	artment of I			iene 006	13499		
· 10		1. Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death		
Physic		Sara Elizabe	th Wil	L1ey			Month April	18, 2006			
/Medi Exami		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of De	<u> </u>	4c. County of De			
LXuilli	eseis:	23990 Willey Way			Но	11ywood		St. Mary's			
Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 h	Irs. 8 Date of Birth	9 B	rthplace (State or Foreign		
Director		214-12-0841	M 2 💢 86	Yrs.	Months Days	Hours M	lin. (Month, Day, August 1	7.1919 M	Country)		
D		Usual Residence of Decedent									
how	_	10a. State 10b. County	100	:. City, Town or L	ocation				10d. Inside City Limits		
a-f s	cto	Maryland St. M	lary's		Holly	wood			1 Yes 2 XNo		
15 th	Director	10e. Street and Number			10f. Zip Code		11	og. Citizen of What C	Country?		
th wi	a	23990 Willey Way			20	)636		United S	tates		
eep su	Funeral	11. Marital Status	2. Was Decedent Ever Amed Forces?	in U.S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or No- ierto Rican, etc.)	14. Race · Am Black, Wh			
affe or It	F	1 XNever Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 ☒ No		,	Specify: W			
21215-0036  ad within 72 hours after deeth with the Maryland glene.  glene than "nature!, or liems 23s or 28s-f show it than "nature!; in Medical Examplination to actificate at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								
72 t	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kind of Busines	s/Industry		
within then	E D	Elementary/Secondary (0-12)	College (1-4or 5+)	iire.	DO NOT use retire	,		11 1 -	.1		
N post	ပိ	17. Father's Name (First, Middle, Last)	2		Register		ie Name (First, Middle, N		hcare		
and 2 be filed ntal Hygi	Be							,			
farylan 2 should be and Mental is marked reumetic ev	ြိ	Charles Willey  19a. Informant's Name/Relationship (Type	no Orint)	105 1450	an Address (Chron		el Fletche Rural Route Number,		Zin Code)		
Maind 2 strath and 27 ts r	7 8	i									
Baltimore, Maryland 21215-0036  semit Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene.  mportant: If Itam 27 is marked other than "natural", or items 23s or 28s-1 show into yor other traumatic event, the Medical Examinar must be publified at note.		Kathy Glockner / 1 20a. Method of Disposition		Db. Place of Disp		Beach, I	Leonardtown Date	n, Marylar 20c. Location - City o			
imore, I Pages 1 and ment of Heath ant: If Itam 2 ury or other		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cre	matory or other pla			•			
Baltimo		4 □Donation 5 □ Other (Specify)		rinsfiel	d-Echole	Cr. 4-1	19-2006 CI	narlotte H	Hall, MD		
Bal permil Deper Import	1	21. Signature Fune 11 nute Ocense	//				rinsfield 1				
40204		Edward N. Brinsfit							20650-0279		
		23a Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.	death. Do not en	ter the mode of dyi	ng, such	diac or best fatory arre	est,	Approximate Interval Between Onset and Coatti		
Pnysician	0.0	Immediate Cause (Final disease or condition	Ca	ideas	-Hord	ulhi	nea)	1	menuter		
/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of:	1	10-11	11 1/5	<del></del>	1		
Lxammer	L.	Sequentially list conditions, b	Acc	de /	woods	sull!	merce	M	V(		
p ±	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ar as a cor	nsequence of):	1. 1	X.	100		NO V		
ecute and -trans	cam	that initiated events cresulting in death) Last	Due to (or as a cor	20na	MIN	asy	1475		901		
50, se ex	Ê		Due to (or as a cor	isaquarica oi): •		Y					
.O. Box 68760, the death certificate be executed y the attending physician and tohed for use as the burial-transit	dicai	<b>€</b> d			/				V		
Box 68 eath certific attending pl	Mec	IF FEMALE:	D. W								
Box eath cert attendin for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1☐Live birth 2☐	Fetal death 3	⊒Ectopic pregnanc	y		23d. Date of d	elivery Day Year		
O. In the a	sic	1 ☐ Yes 2 ♠No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)						
P.O. that the de ed by the detached	F.	Part II. Other significant conditions con	taibution to double but an			ALLE PART	220 Did tob		to the cause of death?		
ords, P	5	Part II. Other significant conditions con	thouting to death but no	t resulting in the t	indenying cause gi	ven in Part i.	1 \( \text{Ye}		Probably 4 Unknown		
Cord w require been si should it	ted						-	5 2 2 140 3 1	TODADIY 4 DOTKHOWN		
S S E	ple						24a. Was ar autops		autopsy findings available completion of cause of		
The I	Completed						perform 1 ☐ Yes 2	ned? death? ✓ No 1 ☐ Ye	s 2 🖾 No		
Vital sician: T certificati irector, pa	Be	25. Was case referred to medical examiner?					Death (Check only one	9)			
hysic his co	2	1 ☐ Yes 2 No H	ospital: 1  Inpatient	2 ER/Outpatie	nt 3□ DOA Ott	her: 4 🗆 Nursin	g Home 5 💢 Reside	nce 6 Other (Sp	ecify)		
n G ng P fter t	ä	27. Manner of Death  1   ↑ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	of 28c. Inju Wo	ry at rk?	28d. Describe ho	w injury occurred			
Attending r death.	ati	2 Accident investigation			M 1	]Yes 2 □No	_				
Division of I or Attending Phy after death. Director: After this d in by the tuneral d	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st pecify)	reet, factory, office		28f. Location (Str City or Town	eet and Number or F , State)	Rural Route Number,		
Ital of irs af	Ce										
Hosp thou tune Tune	edical	29a. Certifier 1 Certifying Phys	icien: To the best of my	knowledge, deal	th occurred at the tr	me, date and pla	ace, and due to the ca	use(s) and manner a	is stated.		
the Prin 24 the P	ledi	one)	and manner stated.								
Division of Vital I To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this cértificate completely filled in by the funeral director, pa	Σ	29b. Signature and title of certifier	$U \parallel . \parallel .$	11	29c. Licens	se number	29	9d. Date signed (Mor	nth, Day, Year)		
	0	James-	DVWO	EM	DI	) 06 t	17	7-19	1-06		
		30. Name and add 4s. of person who co	11		· ·						
,	1//	James P. Jarboe, N			otch Road	d, Holly	wood, Mary	land 2063	6		
	ate	31. Date filed (Month Pay 1 9 200)	6 Registrar's S	signature	all i						
Regist	rar	,		-							

		•	_	
or	State of Maryland / Department of Health and Ment	al Hygiene	nr	1000
State	Cartificate of Dooth	£	CF 5	3

	Physici /Medic		1- State Registrar Certificate of Death Reg. No.									
		an	Decedent's Name (First, Middle, Last)						eath Day	Year	3. Time of Death	
-			Mildred Alma Williamson					April	19	2006	1908 M	
	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death						4c. County of Death			
			PUNINSULA SUGIONAL 5. Social Security Number 6. Se	x 7. Age (In yrs.	last highday) If	ے Jnder 1 Year	If Under 24 Hrs.	8. Date of Bi	rth.	,,,,		
3	Funeral Director			л жДж // лук /// // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // лук // л	78 Yrs. Mc	nths Days		Jan. 2	9.192		place (State or Foreign htry) ryland	
80	within 72 hours after death with the Maryland ane. then "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at		Usual Residence of Decedent							IIa	Tyland	
0		_	10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits   $MD$   Caroline   Federals burg   1 $\square$ Yes 2 $\square$ No									
82		Director	MD Caroli	ne			ourg				1 ☐ Yes 2 ☐ No	
213-22-9080		듬	10e. Street and Number	11	10f. Zip Code 21632			_	n of What Cour	·		
213		Funeral	2936 Mowbray Creek Road  11. Marital Status 12. Was Decedent Ever in U.								States e - American Indian,	
a	or Iten	뎚	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 📆 No				Rican, etc.)		Black, White,	etc.	
3 6	ours a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2XI No Specify:				S	pecify: Wh	ite	
5-0	72 hours "natural", edicel Exe	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's	Usual Occup of work done	pation during most of work d)	kina	16b. Kind	of Business/In	dustry	
121	vithin ne. hen.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	Seamst		nd)	•	Spor	tswear		
Mulchu 0 d 21215-003	be filed within 72 h hal Hygiene. nd other then "natu event, the Medical	e Co	10 17. Father's Name (First, Middle, Last)		Deams	.1 035	18 Mother's Nam	e (First Middle				
an /	permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiens and Important: If tem 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exampance.	To Be	Edward Cox			18. Mother's Name (First, Middle, Maiden  Della Alexander				•		
<i>β</i> Σ		1	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Ad	dress (Street	and Number or Rui	al Route Numb	er, City or T	own, State, Zip	Code)22225	
บใในสหารอก ุ altimore, Marylar			Wayne W. Willia	amson/Son	12402	Sile	nt Brook	Trail	L, Ja	cksonvi	11e, FL	
are			20a. Method of Disposition	2 Change	lace of Disposition emetery, cremator	y or other pla	ce)	Date		tion - City or To		
3 E			Bloomery Cemetery 04/23/06 Federalsburg, MD									
3alt			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A.									
	40 = 4 a	-	Mulad 4. Wew 216 N. Main St., Federalsburg, MD 21632									
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Onset and Death									
	Physician /Medical		disease or condition resulting in death)	a. Stroke								
	Examiner			Due to (or as a consequ	Jence of):							
	-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequ	ience of):							
	icate be executed physicien and s the burial-transit	Examiner	that initiated events	c								
Ö,	e exe tien a urial-t		resulting in death) Last	Due to (or as a consequ	ience of):							
68760,	cate b	Medical	•	d			<del></del>					
	ding p		IF FEMALE:	23c. If yes, outcome of pregna	ncv							
Bo	leath ce ettendii I for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2. ■ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 ☐Ecto	pic pregnancy er (specify)	у		230	<li>d. Date of delive Month</li>	ory Day Year	
o.	thet the de ned by the e	hysi	9 Unknown	9□ Unknown								
0	es the igned be det	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?									
ğ	The law requires thet the death certificate be executed to hes been signed by the ettending physicien and bage 2 should be detached for use as the burial-transi	ted	Ci-disvirely disere					1 🗆	1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown			
ဝင္ပ	e lawr hes be je 2 sh	Completed						24a. Was	an a	24b. Were auto	psy findings available npletion of cause of	
<u>=</u>	The I	Con						perfo 1 ☐ Yes		death? 1 ☐ Yes	2□ No	
Division of Vital Records,	iing Physician: 1. After this certific funeral director,	Be	25. Was case referred to medical examiner?  26. Place of Death (Check only one)									
		Certification; To	1   Yes 2 No							y)		
O			1 Natural 5 Pending 2 Accident investigation	Injury				28d. Describe how injury occurred				
Visi	or Attence after death Director: d in by the		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, f				t, factory, office 28f. Loca			ation (Street and Number or Rural Route Number,		
Ö	talor rs afte al Dir		4 Homicide determined building, etc. (Specify)									
	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	edical	(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat	vledge, death occ	urred at the tir	me, date and place,	and due to the	cause(s) an	nd manner as st	ated.	
	thin 24 thin 24 the F	Medi	one)  29b. Signature and title of cattrier	and manner stated.								
	To To		Zou. Signature and title of certifier			29c. Licens	Se number			signed (Month,		
		1 1	1/0	n 0		11154	V 14		1766	1102 10	0	

Registrar DHMH 17 Rev 1/2001

State

M.(g. TREUTHMD)
31. Date filed (Month, Day, Year)

100 €

2006

SHlisbury Ma 21801